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: XZTS
Facility ID: 00695

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/19/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **02 SNF/NF/Dual** **03 SNF/NF/Distinct** **04 SNF** **05 HHA** **06 PRTF** **07 X-Ray** **08 OPT/SP** **09 ESRD** **10 NF** **11 ICF/IID** **12 RHC** **13 PTIP** **14 CORF** **15 ASC** **16 HOSPICE** **22 CLIA**

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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:

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

* Code: A (L12)

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Wendy Dobie, HFE NE II 12/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
CMS Certification Number (CCN): 245522

December 26, 2018

Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

Dear Administrator:

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

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

Effective December 4, 2018 the above facility is certified for:

51   Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

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

Electronically delivered
December 26, 2018

Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Number S5522030

Dear Administrator:

On November 13, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective November 18, 2018. (42 CFR 488.422)

- **Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2019.**

This was based on the deficiencies cited by this Department for a standard survey completed on October 25, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 19, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 7, 2018 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 October 25, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 4, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 25, 2018, as of December 4, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 4, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 21, 2018:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective [Cycle Start + 3 Months()] be rescinded as of December 4, 2018. (42 CFR 488.417 (b))

- Civil money penalty. (42 CFR 488.430 through 488.444)

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

cc: Licensing and Certification File

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

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(L9)

6. DATE OF SURVEY **10/25/2018** (L34)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
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* Code: B* (L12)

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17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II HFE NE II 11/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/14/2018 (L20)

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____ 2. Facility is not Eligible
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26. TERMINATION ACTION: (L30)

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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

November 13, 2018

Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Numbers S5522030, H5522017

Dear Administrator:

On October 25, 2018, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the October 25, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5522017 that was found to be unsubstantiated.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department is imposing the following remedy:

- State Monitoring effective November 18, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2019.

Also, this department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2019. They will also notify the State Medicaid

Agency that they must also deny payment for new Medicaid admissions effective January 13, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 13, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Luther Memorial Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

correction occurred sooner than the latest correction date on the ePoC.

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

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 April 25, 2019 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING ______ B. WING ______	10/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/22/18 through 10/25/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H5522017 complaint was investigated and found to be unsubstantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		12/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING ______ B. WING ______	10/25/2018

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

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 580	F580	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST MADELIA, MN 56062**

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F 580	Continued From page 2 review the facility failed to notify the physician of a change in skin condition resulting in a painful pilonidal sinus tract for 1 of 3 residents (R6) reviewed with skin issues. Findings include: When interviewed on 10/22/18, at 03:26 p.m. R6 stated having a sore on his butt that had been there for a few weeks. Resident stated the area really hurt when staff got him up in the morning or put him to bed at night and continued to hurt for about 6 hours afterwards. R6 confirmed the pain didn't hurt that bad at the time of the interview but there was always a dull pain. R6 stated, "They give me some kind of medicine but it doesn't take the pain away. They blamed it on me sitting too much which is probably true." R6's quarterly Minimum Data Set (MDS) assessment dated 8/2/18, indicated the resident had intact cognition and required extensive assistance with bed mobility, transfer, locomotion on/off the unit, dressing, and toilet use. The MDS further identified diagnoses including diabetes and urinary incontinence. R6's care plan copied 10/24/18, indicated a potential for impaired skin integrity and at risk for skin breakdown. Approaches included to monitor skin daily with cares and report changes to the charge nurse, and nurse to conduct a weekly skin assessment on bath day. R6's care plan also identified a potential for intermittent pain. Approaches included: Assess physical symptoms. Anticipate pain and treat. Ask about pain regularly. Administer pain meds and note effectiveness/adverse effect. Assess need for scheduled analgesics. Notify physician of	F 580	While we do not believe the situation described in this summary rose to the level of a deficient practice, we offer the following: 1) R6 has resided at this facility since October 2016. He reports that he has no complaints with the timing that this facility offers of notifying his providers of health concerns. R6s complaint of pain as reported by the Ombudsman Volunteer on 10/22 as possibly being related to sciatica may have resulted in a delay in R6 being examined by his provider. A therapy screening was completed on 10/24/18 where it was determined by interview that R6 wanted us to know that the pain he felt in his bottom was a result of a very large BM that hed had on 10/21/18. The Therapy Department ruled out a musculoskeletal cause of the pain. The Provider was notified of the situation on 10/25 and R6 was seen by his provider on 10/26/18 and diagnosed with a pilonidal sinus (PNS). Treatment orders are being followed. 2) All residents of this facility have the potential of being affected by this alleged deficient practice. 3) A big lesson learned was to receive the information provided by the Ombudsman Volunteer and then to circle back with each resident identified in her report to verify and clarify the information so that an effective plan of action to address concerns can be started. A log will be	

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F 580	Continued From page 3 changes. Review of R6's progress note dated 8/7/18 at 1:51 p.m., indicated: NAR (nursing assistant registered) reported a blister on inner right buttocks near coccyx. Noted a intact 2.8 cm (centimeter) by 1 cm clear fluid filled blister. Light pink in color. NAR reported was not noted this AM. Resident denies pain to area. Cleansed and applied skin prep. See N.O. (nursing order) on TAR (treatment administration record). Further review of R6's progress notes revealed the blister on the resident's R inner buttock opened on 8/10/18 and was described as light pink and moist. The progress notes indicated staff continued to monitor and provide treatment to the area. The progress note dated 9/29/18 at 7:28 a.m. indicated: Skin tx done per order to right inner buttocks. Noted opened, healing blister remains to be 0.5 cm light red and appears moist. States it is "tender" to touch and feels better when sitting or laying. No drainage or swelling to area noted. Review of the Licensed Nurse Weekly Skin Assessments indicated: 10/4/18 (per electronic health record-EHR) -AREA 3: Gluteal cleft SURROUNDING TISSUE: No redness warmth or edema noted. HEALING PROGRESS: improving - area was a blister as noted in nurses' documentation. DESCRIPTION: appears more clean, improving. DRAINAGE/EXUDATE: note present. ODOR: None noted. TREATMENT: Protective dressing in place. Area is moist, gluteal crease is deep. Encouraged repositioning to shift from area and to keep protective dressing in place. Notify Physician with changes or concerns. AREA:	F 580	kept when the Ombudsman Volunteer visits, recording the information she reports. Priority will be given to issues such as reported pain and will be assessed by an RN within the reported shift. We will ask that she have an exit conference with either the DON or Social Service Director for consistency in this process. The log will be reviewed weekly at the IDR Team meeting and summarized at the QAPI meeting. We will request the providers and our medical director to review the policy titled Reporting Conditions to the Physician, seeking feedback and we will revise the policy in response to that feedback. 4) RN Managers will continue to be the first line of monitoring by reviewing the 24-Hour Report in the EHR. They can see which issues the charge nurses reported to the providers in the past 24-hours, noting what needs to be followed. They are in a better position to notice trends in reported issues and will also continue to report concerns to the providers. The RN Managers will also maintain our existing positive relationships with the providers who round on-site on a weekly basis. Changing conditions will continue to be reported and examined as they arise. The DON will continue to be responsible for ensuring that this policy is followed. She will conduct weekly look-behind audits from the 24-Hour Report for 1-quarter and report results at the QAPI meeting.	

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length (cm): 1.2 width (cm) 1.4 depth utd (unable to determine). COMMENTS: Gluteal crease moist, protective dressing in place. Routine skin checks with bath day by nurse. [Resident name] denies pain with this area unless "you monkey with it".

10/12/18 - (per paper copy) R gluteal cleft marked on body diagram and indicated: area red, not open, looks some better from last week.
10/19/18 - (per paper copy) R gluteal cleft marked on body diagram and indicated: no dressing, too moist, not open, moist-will try skin prep, pain only if I push on it & keep "messing" with areas.

Further review of R6's progress notes indicate:
10/21/18 at 11:21 a.m. SKIN PROBLEMS: buttocks, inner gluteal fold remain red. No open areas. Skin protectant applied.
10/22/18 at 3:06 p.m. SKIN PROBLEMS: buttock, inner gluteal fold remain red. No open areas. Skin protectant applied.
10/23/18 at 10:49 a.m. PROCEDURE DONE: Continue to monitor. Skin prep applied to upper, inner gluteal fold, tissue is red.
10/23/18 at 11:50 a.m. Note: [Name], Ombudsman volunteer visited with this writer regarding resident [Resident name]. Stated he was not himself today when she was in to visit him and that he was crabby and complaining of pain she feels might be related to sciatica. This writer and [Ombudsman volunteer name] agreed that a therapy consult would be a good option to start with to see if they can help treat the pain. Also reviewed resident's medicaiton list and noted that he doesn't have anything scheduled for pain buy has as needed Tylenol which he hasn't used. Will add pain monitoring to the to-do list for every shift. Will notify NP (nurse practitioner) when at

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facility 10/24 or sooner if the need arises.

R6's medical record did not include evidence the physician or nurse practitioner had ever been notified of the ongoing skin issue on the residents R inner buttock.

When interviewed on 10/24/18, at 7:24 a.m. R6 indicated his bottom, "Feels like a bumble bee stung it". Resident also stated his bottom felt like that all day and the staff, "Put some crap on it". Resident agreeable to surveyor observing his bottom when toileted.

On 10/24/18, at 10:10 a.m. NA-D was observed providing toileting assistance for R6 utilizing a standing lift. Upon lowering the resident's pants and brief a foam dressing was noted covering the coccyx area. The dressing was crinkling up and NA-D stated it looked like it needed to be changed. Upon lifting the dressing it was noted to be covered with a reddish-brown drainage; R6's right (R) upper inner buttock near the coccyx had a open area approximately 2 cm x 1 cm that was whitish around the outer edges with a wound bed that was pinkish-red. NA-D confirmed the resident's R buttock had previously had an open area but not that big. NA-D stated they had been treating R6's bottom with skin prep as the outer skin surrounding the coccyx area previously was bright red but now looked much better. NA-D refastened the resident's dressing, lowered the resident onto the commode, then indicated she would go and get the nurse.

On 10/24/18, at 10:24 a.m. licensed practical nurse (LPN)-B was observed providing a dressing change to R6's coccyx. LPN-B cleansed hands,

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F 580	Continued From page 6 donned gloves and removed the existing dressing on R6's coccyx. LPN-B then doffed gloves, donned clean gloves, then asked NA-D to obtain a wet and a dry paper towel. LPN-B cleansed the R inner buttock wound with the wet paper towel then patted dry with the dry paper towel. LPN-B then measured the wound which was 2 cm long (L) x 1.2 cm wide (W); LPN-B then applied a new foam dressing to R6's coccyx covering the R inner buttock wound. R6 was visibly uncomfortable during the dressing change, grimacing and stating, "Take your time but hurry up!", resident verified that his bottom hurt. When interviewed upon exiting the resident's room, LPN-B confirmed the open area on R6's R inner buttock was worse since she had visualized it the week prior. LPN-B further confirmed the treatment to the R inner buttock was to apply skin prep daily and they had not been covering the area. LPN-B stated registered nurse (RN)-C assesses and measures R6's wound on the resident's bath day which is Thursdays. LPN-B further stated staff encourage the resident to reposition every 2 hours which he was not always compliant with; the resident would usually lay down after lunch and staff encourage him to turn from side to side but he wasn't always agreeable to that either. R6's progress note dated 10/24/18 at 10:33 a.m. indicated: SKIN PROBLEMS: Noted in inner buttock crease to have an 1.2 x 2 cm open area, scant amount of bright bleeding on old dressing. Area cleansed, skin prep applied, and new dressing applied. Encouraged to reposition every two hours, agreeable at the time. When interviewed on 10/25/18, at 8:44 a.m. surveyor asked R6 how his bottom was feeling,	F 580		

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F 580	Continued From page 7 resident stated, "I can feel it. It hurts". When interviewed on 10/25/18, at 8:47 a.m. RN-B confirmed R6 had complained over the weekend (10/20/18 & 10/21/18) of his bottom hurting. RN-B stated the resident's bottom was red at that time with no open areas. RN-B stated R6's treatment to the coccyx was changed 10/19/18 from applying skin protectant cream to applying skin prep to the coccyx area and that's what was used over the weekend. On 10/25/18, at 9:05 a.m. NA-D confirmed R6 had been complaining of pain on his bottom for at least a week and that was why his treatment was changed. NA-D was unaware if R6 was receiving anything as needed for pain other than scheduled medications. On 10/25/18, at 9:27 a.m. RN-B was observed providing treatment and dressing change to R6's R inner buttock. Upon entering the residents room, R6 was observed seated in his recliner; surveyor noted a cushion on the seat of R6's wheelchair (w/c); the cushion had a rigid cover on it which was crinkled up rather than smooth. R6 confirmed having the same w/c cushion since admission to the facility and stated, "Get a hammer and pound it smooth". NA-G was present in the room and confirmed the cover was firm and crinkled; NA-G removed the w/c cover and stated she would find a softer cover for the resident's cushion. R6 was then raised up out of his recliner with a standing lift by NA-G and RN-B proceeded to provide treatment to R6's R inner buttock wound. RN-B cleansed the wound with wound cleanser and patted dry with clean gauze. RN-B measured the wound on R6's right inner buttock; the wound bed was red with whitish	F 580		

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F 580	Continued From page 8 edges with an area in the center of the wound that was whitish in color. The wound measured 2 cm x 0.9 cm; the small whitish area in the center of the wound measured 0.7 cm x 0.4 cm. RN-B confirmed the area on R6's R inner buttock had worsened since the previous weekend when she last visualized it. RN-B stated she could tell something had been there referring to the previous blister but is was not open and not that big. When interviewed on 10/25/18, at 11:30 a.m. RN-C stated being unaware R6 had an open area on his R inner buttock. RN-C stated the resident previously had a blister on his buttocks near the coccyx that was taken care of and to her knowledge the area had been doing better. RN-C reviewed the last skin assessment she had conducted in the electronic record dated 11/4/18; RN-C stated she had assessed the area since then on a paper form but was unable to locate at that time. RN-C thought the physician had been notified of the wound on the resident's buttock when it had opened but was unable to locate evidence as such. RN-C stated she had contacted the nurse practitioner earlier that day of the blistered area on R6's left heel that had been identified by the night shift last evening but did not about the resident's coccyx. RN-C confirmed the ombudsman volunteer was at the facility on 10/24/18 and shared that the resident was reporting pain she thought (the volunteer) might be related to sciatica. RN-C did not think the pain was related to the reddened area on R6's bottom as he had reported the pain as being "inside". RN-C further stated the director of nursing (DON) had talked with therapy about the pain R6 was describing; therapy had indicated they couldn't do anything about it if it was inside. RN-C then	F 580		

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F 580	Continued From page 9 stated, "It's his anus that hurts apparently". RN-C confirmed she did not do a visual assessment of R6's bottom with the recent complaints of pain. When interviewed on 10/25/18, at 1:49 p.m. the DON stated if a resident had a new skin issue like a open slit in the coccyx area, they wouldn't necessarily contact the physician if they could manage the area on their own. DON stated when she talked with the ombudsman volunteer on 10/24/18, it sounded more like a muscular issue as the pain was described as going down his leg like sciatica. DON stated she had the resident see Occupational Therapy (OT) and also set up pain monitoring for the resident. DON indicated the resident had a PRN (as needed) Tylenol order that he hadn't been utilizing and encouraged the staff to offer if the resident complained of pain; DON confirmed a visual assessment of the residents bottom had not been conducted when the ombudsman volunteer had shared the resident's complaints of pain. DON further confirmed she would have expected the nurse yesterday to pass on that R6 had an open area near the coccyx. DON stated she would set up an appointment with the physician to evaluate R6's open wound and also the complaints of internal pain. The Physician's Plan of Care and Discharge Orders dated 10/26/18, included: This is a pilonidal sinus tract (A pilonidal sinus (PNS) is a small hole or tunnel in the skin. It may fill with fluid or pus, causing the formation of a cyst or abscess. It occurs in the cleft at the top of the buttocks). It is draining. Does not require antibiotics or surgery. Cleanse with Dakins solution once daily. Apply silver Aquacel to base	F 580		

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F 580	Continued From page 10 and cover with Mepilex. Report any additional swelling or increased redness of the site. Follow up visit in 2 weeks. The policy/procedure titled Reporting Conditions to the Physician, dated 9/23/18, included: Protocol For - The charge nurse is responsible for immediately notifying the Physician, Nurse Practioner and family if the resident experiences a change in status, and has a reasonable potential for negative outcome, example include, but are not limited to: - Any new pain or change in pain level that is not relieved with the use of ordered PRN medications. - Any signs or symptoms of an infectious process: redness, swelling, heat pain, drainage, urinary or respiratory symptoms etc.	F 580		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living.	F 676		11/28/18

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F 676	Continued From page 11 The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure shaving was provided for 1 of 3 residents (R196) who required staff assistance with grooming. Findings include: R196's electronic health record (EHR), indicated the resident had been admitted to facility on 10/11/18, with diagnoses including osteoarthritis and weakness. R196's admission Minimum Data Set (MDS) assessment dated 10/19/18, identified R196 with a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS further identified R196 required limited assistance with personal hygiene.	F 676	F676 1) R196 has resided at this facility since 10/9/18. He requested and received professional hair care services on 10/11/18, which included what he calls, a professional shave. In interviewing more of his direct caregivers, we learned that R196 routinely did have his grooming needs met, including shaving. He was not offered shaving on 10/24/18 by NA-E, but this should not be interpreted that care rises to the level of a deficiency by this NAR or any caregiver at this facility on a routine basis. R196 had an early appointment which required a change in his morning routine. His caregivers stated in interview that he does not shave daily.	

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Continued From page 12

R196's care plan dated 10/16/18, indicated the resident had a self-care deficit and required assistance of staff for grooming and shaving every morning.

During observation and interview on 10/22/18 at 3:33 p.m., R-196 had dark gray facial hair covering his upper lip, chin, neck and cheek areas. R196 stated he liked having a mustache but didn't want a beard.

During observation and interview on 10/24/18, at 7:04 a.m. R196 was dressed and eating breakfast in his room. Facial hair remained present on his cheeks, chin, and neck. R196 stated he would like to be shaved but staff had not offered with cares. He further stated he had his own electric razor but needed assistance from staff to shave.

During interview on 10/24/18, at 7:59 a.m. family member (FM)-A stated R196 usually wore a mustache, but never a beard, and indicated the facial hair on his cheeks, chin, and neck was not his usual appearance.

During interview on 10/24/18, at 10:42 a.m. nursing assistant (NA)-E verified she had not offered to assist R196 with shaving during morning cares. NA-E further stated she didn't think R196's family had brought a razor yet.

During interview on 10/24/18 at 1:34 p.m., NA-F confirmed R196 had "several days worth of long whiskers" and desired to be shaved. NA-F further stated R196 had his own razor and residents should be offered shaving "everyday or every other day for sure".

F 676

Grooming services, including shaving, are offered to R196 daily and appointments are made with the beautician for a professional shave as requested. R196 maintains his right to refuse to shave.

2) All residents have the potential for being affected by this alleged deficient practice.

3) We will continue to follow the policy titled Providing Adequate & Proper Nursing Care. Re-education of the NARs who are assigned to R196□s care was provided, including the information that he owns his own razor and the information regarding his preference to maintain a mustache. We will continue to offer him access to the beautician for hair care services, including a professional shave.

4) The DON or someone she delegates the responsibility to will monitor the grooming and satisfaction with grooming services for all residents. This may be done through observation and interview. A Performance Improvement Plan (PIP) will be considered at the next QAPI meeting.

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F 676	Continued From page 13 On 10/25/18 at 9:57 a.m., the director of nursing (DON) stated shaving is part of routine cares and would expect staff to complete daily during morning cares. A facility policy titled Providing Adequate & Proper Nursing Care last reviewed 10/1/12, included: 1) Assist with or provide supervision of shaving of all residents as necessary to keep them clean and well-groomed.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care for 1 of 3 residents (R42) reviewed for activities of daily living who was dependent on staff for assistance. Findings include: When interviewed on 10/23/18, at 8:39 a.m R42 stated staff don't always brush her teeth. Resident further stated some staff were better than others and if they would just give her the supplies she would do it herself. R42's admission Minimum Data Set (MDS) dated 10/5/18, indicated the resident had intact cognition and required extensive assistance with bed mobility, transfer, walk in room, locomotion on/off unit, dressing, toilet use, and personal	F 677	F677 1) R42 expired on 10/25/2018. 2) All residents of this care facility are assessed upon admission and at least quarterly as to whether they are independent or require assistance with activities of daily living (ADL). Preferences in how the ADL is performed is taken into consideration when practical and possible. 3) We will continue to follow the policy titled Providing Adequate & Proper Nursing Care. Re-education will be provided at the next NAR meeting on November 29th.	12/4/18

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F 677	Continued From page 14 hygiene. The MDS further identified the resident as receiving hospice services. R42's care plan dated 10/1/18 indicated the resident required supervision and set-up assistance with oral care. On 10/24/18, at 9:38 a.m. R42 was observed seated in a recliner in her room and had just finished breakfast. When asked if staff had offered to brush her teeth or obtain the supplies for her to do it herself the resident confirmed they had not. When interviewed on 10/24/18, at 1:22 p.m. nursing assistant (NA)-D confirmed R42 required assistance with most of her activities of daily living. NA-D stated the resident was able to feed herself but required assistance with toileting, dressing, transferring, and oral cares. NA-D stated she offered the resident salt water rinses as that was on the TAR (treatment administration record), though did not offer toothbrushing to the resident as she had complained of mouth pain. NA-D further stated R42 was gotten up in the morning by the night shift though she did notice the resident's mouth appeared dirty yet did not offer toothbrushing. NA-D and surveyor entered R42's room as the resident was awake; R16 was drinking a glass of chocolate milk. NA-D asked the resident if she would like to brush her teeth. R42 indicated she was finishing her drink. NA-D then asked the resident if she would like to brush her teeth after she was finished drinking her milk and the resident stated that she would. NA-D stated she would return in a few minutes to assist with brushing her teeth. When interviewed on 10/25/18, at 11:26 a.m., the	F 677	4) The DON or someone she delegates the responsibility to will monitor the hygiene and satisfaction with hygiene services for all residents for a month following the re-education meeting. This may be done through observation and interview. Results will be reported at the QAPI meeting. If adequate improvement is not noted, a Performance Improvement Plan (PIP) will be recommended.	

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F 677	Continued From page 15 director of nursing (DON) stated she would expect staff to be offering toothbrushing as well as the salt water rinses for R16 unless there had been some direction to do one over the other.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and monitor pain related to a skin wound for 1 of 3 residents (R6) reviewed with skin issues. Findings include: When interviewed on 10/22/18, at 03:26 p.m. R6 stated having a sore on his butt that had been there for a few weeks. Resident stated the area really hurt when staff got him up in the morning or put him to bed at night and continued to hurt for about 6 hours afterwards. R6 confirmed the pain didn't hurt that bad at the time of the interview but there was always a dull pain. R6 stated, "They give me some kind of medicine but it doesn't take the pain away. They blamed it on me sitting too much which is probably true."	F 684	F684 1) R6 has resided at this facility since October 2016. R6's complaint of pain as reported by the Ombudsman Volunteer on 10/22 as possibly being related to sciatica may have resulted in a delay in R6 being assessed accurately by our care team. R6 had a therapy screening on 10/24/18 by PT where it was determined by interview that R6 wanted us to know that the pain he felt in his bottom was a result of a very large BM that he'd had on 10/21/18. The therapy department ruled out a musculoskeletal cause of the pain. R6's provider was notified of this information on 10/25 and was seen by his provider on 10/26/18 and diagnosed with a pilonidal sinus (PNS). Treatment orders are being followed.	12/4/18

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R6's quarterly Minimum Data Set (MDS) assessment dated 8/2/18, indicated the resident had intact cognition and required extensive assistance with bed mobility, transfer, locomotion on/off the unit, dressing, and toilet use. The MDS further identified diagnoses including diabetes and urinary incontinence.

R6's care plan copied 10/24/18, indicated a potential for impaired skin integrity and at risk for skin breakdown. Approaches included to monitor skin daily with cares and report changes to the charge nurse, and nurse to conduct a weekly skin assessment on bath day. R6's care plan also identified a potential for intermittent pain. Approaches included: Assess physical symptoms. Anticipate pain and treat. Ask about pain regularly. Administer pain meds and note effectiveness/adverse effect. Assess need for scheduled analgesics. Notify physician of changes.

Review of R6's progress note dated 8/7/18 at 1:51 p.m., indicated: NAR (nursing assistant registered) reported a blister on inner right buttocks near coccyx. Noted a intact 2.8 cm (centimeter) by 1 cm clear fluid filled blister. Light pink in color. NAR reported was not noted this AM. Resident denies pain to area. Cleansed and applied skin prep. See N.O. (nursing order) on TAR (treatment administration record).

Further review of R6's progress notes revealed the blister on the resident's R inner buttock opened on 8/10/18 and was described as light pink and moist. The progress notes indicated staff continued to monitor and provide treatment to the area. The progress note dated 9/29/18 at 7:28 a.m. indicated: Skin tx done per order to

F 684

2) All residents of this care facility are assessed upon admission and at least quarterly, bearing the responsibility of ensuring that they receive treatment and care according to provider orders, standards of care, and personal preference when possible and practical. This assessment includes areas of concerns related to pain, skin care, wound care, risk of injury from falls, etc.

3) A big lesson learned was to receive the information provided by the Ombudsman Volunteer and then to circle back with each resident identified in her report to verify and clarify the information so that an effective plan of action to address concerns can be started. A log will be kept when the Ombudsman Volunteer visits, recording the information she reports. Priority will be given to issues such as reported pain and will be assessed by an RN within the reported shift. We will ask that she have an exit conference with either the DON or Social Service Director for consistency in this process. The log will be reviewed weekly at the IDR Team meeting and summarized at the QAPI meeting. We will request the providers and our medical director to review the policy titled Reporting Conditions to the Physician, seeking feedback and we will revise the policy in response to that feedback.

4) The MDS Coordinator will continue to be responsible for conducting pain assessments for all residents upon

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F 684	Continued From page 17 right inner buttocks. Noted opened, healing blister remains to be 0.5 cm light red and appears moist. States it is "tender" to touch and feels better when sitting or laying. No drainage or swelling to area noted. Review of the Licensed Nurse Weekly Skin Assessments indicated: 10/4/18 (per electronic health record-EHR) -AREA 3: Gluteal cleft SURROUNDING TISSUE: No redness warmth or edema noted. HEALING PROGRESS: improving - area was a blister as noted in nurses' documentation. DESCRIPTION: appears more clean, improving. DRAINAGE/EXUDATE: note present. ODOR: None noted. TREATMENT: Protective dressing in place. Area is moist, gluteal crease is deep. Encouraged repositioning to shift from area and to keep protective dressing in place. Notify Physician with changes or concerns. AREA: length (cm): 1.2 width (cm) 1.4 depth utd (unable to determine). COMMENTS: Gluteal crease moist, protective dressing in place. Routine skin checks with bath day by nurse. [Resident name] denies pain with this area unless "you monkey with it". 10/12/18 - (per paper copy) R gluteal cleft marked on body diagram and indicated: area red, not open, looks some better from last week. 10/19/18 - (per paper copy) R gluteal cleft marked on body diagram and indicated: no dressing, too moist, not open, moist-will try skin prep, pain only if I push on it & keep "messing" with areas. Further review of R6's progress notes indicate: 10/21/18 at 11:21 a.m. SKIN PROBLEMS: buttocks, inner gluteal fold remain red. No open areas. Skin protectant applied.	F 684	admission, quarterly, and as warranted based on resident condition and situations (e.g. readmission from hospital, significant change). The DON will audit this process for one quarter to ensure that the system effectively results in residents pain being assessed and treated in accordance to policy. She will report results at the QAPI meeting.	

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10/22/18 at 3:06 p.m. SKIN PROBLEMS: buttock, inner gluteal fold remain red. No open areas. Skin protectant applied.
10/23/18 at 10:49 a.m. PROCEDURE DONE: Continue to monitor. Skin prep applied to upper, inner gluteal fold, tissue is red.
10/23/18 at 11:50 a.m. Note: [Name], Ombudsman volunteer visited with this writer regarding resident [Resident name]. Stated he was not himself today when she was in to visit him and that he was crabby and complaining of pain she feels might be related to sciatica. This writer and [Ombudsman volunteer name] agreed that a therapy consult would be a good option to start with to see if they can help treat the pain. Also reviewed resident's medicaiton list and noted that he doesn't have anything scheduled for pain buy has as needed Tylenol which he hasn't used. Will add pain monitoring to the to-do list for every shift. Will notify NP (nurse practitioner) when at facility 10/24 or sooner if the need arises.

R6's medical record did not include evidence the physician or nurse practitioner had ever been notified of the ongoing skin issue on the residents R inner buttock.

When interviewed on 10/24/18, at 7:24 a.m. R6 indicated his bottom, "Feels like a bumble bee stung it". Resident also stated his bottom felt like that all day and the staff, "Put some crap on it". Resident agreeable to surveyor observing his bottom when toileted.

On 10/24/18, at 10:10 a.m. NA-D was observed providing toileting assistance for R6 utilizing a standing lift. Upon lowering the resident's pants and brief a foam dressing was noted covering the

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coccyx area. The dressing was crinkling up and NA-D stated it looked like it needed to be changed. Upon lifting the dressing it was noted to be covered with a reddish-brown drainage; R6's right (R) upper inner buttock near the coccyx had a open area approximately 2 cm x 1 cm that was whitish around the outer edges with a wound bed that was pinkish-red. NA-D confirmed the resident's R buttock had previously had an open area but not that big. NA-D stated they had been treating R6's bottom with skin prep as the outer skin surrounding the coccyx area previously was bright red but now looked much better. NA-D refastened the resident's dressing, lowered the resident onto the commode, then indicated she would go and get the nurse.

On 10/24/18, at 10:24 a.m. licensed practical nurse (LPN)-B was observed providing a dressing change to R6's coccyx. LPN-B cleansed hands, donned gloves and removed the existing dressing on R6's coccyx. LPN-B then doffed gloves, donned clean gloves, then asked NA-D to obtain a wet and a dry paper towel. LPN-B cleansed the R inner buttock wound with the wet paper towel then patted dry with the dry paper towel. LPN-B then measured the wound which was 2 cm long (L) x 1.2 cm wide (W); LPN-B then applied a new foam dressing to R6's coccyx covering the R inner buttock wound. R6 was visibly uncomfortable during the dressing change, grimacing and stating, "Take your time but hurry up!", resident verified that his bottom hurt. When interviewed upon exiting the resident's room, LPN-B confirmed the open area on R6's R inner buttock was worse since she had visualized it the week prior. LPN-B further confirmed the treatment to the R inner buttock was to apply skin prep daily and they had not been covering the

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F 684	Continued From page 20 area. LPN-B stated registered nurse (RN)-C assesses and measures R6's wound on the resident's bath day which is Thursdays. LPN-B further stated staff encourage the resident to reposition every 2 hours which he was not always compliant with; the resident would usually lay down after lunch and staff encourage him to turn from side to side but he wasn't always agreeable to that either. R6's progress note dated 10/24/18 at 10:33 a.m. indicated: SKIN PROBLEMS: Noted in inner buttock crease to have an 1.2 x 2 cm open area, scant amount of bright bleeding on old dressing. Area cleansed, skin prep applied, and new dressing applied. Encouraged to reposition every two hours, agreeable at the time. When interviewed on 10/25/18, at 8:44 a.m. surveyor asked R6 how his bottom was feeling, resident stated, "I can feel it. It hurts". When interviewed on 10/25/18, at 8:47 a.m. RN-B confirmed R6 had complained over the weekend (10/20/18 & 10/21/18) of his bottom hurting. RN-B stated the resident's bottom was red at that time with no open areas. RN-B stated R6's treatment to the coccyx was changed 10/19/18 from applying skin protectant cream to applying skin prep to the coccyx area and that's what was used over the weekend. On 10/25/18, at 9:05 a.m. NA-D confirmed R6 had been complaining of pain on his bottom for at least a week and that was why his treatment was changed. NA-D was unaware if R6 was receiving anything as needed for pain other than scheduled medications.	F 684		

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On 10/25/18, at 9:27 a.m. RN-B was observed providing treatment and dressing change to R6's R inner buttock. Upon entering the residents room, R6 was observed seated in his recliner; surveyor noted a cushion on the seat of R6's wheelchair (w/c); the cushion had a rigid cover on it which was crinkled up rather than smooth. R6 confirmed having the same w/c cushion since admission to the facility and stated, "Get a hammer and pound it smooth". NA-G was present in the room and confirmed the cover was firm and crinkled; NA-G removed the w/c cover and stated she would find a softer cover for the resident's cushion. R6 was then raised up out of his recliner with a standing lift by NA-G and RN-B proceeded to provide treatment to R6's R inner buttock wound. RN-B cleansed the wound with wound cleanser and patted dry with clean gauze. RN-B measured the wound on R6's right inner buttock; the wound bed was red with whitish edges with an area in the center of the wound that was whitish in color. The wound measured 2 cm x 0.9 cm; the small whitish area in the center of the wound measured 0.7 cm x 0.4 cm. RN-B confirmed the area on R6's R inner buttock had worsened since the previous weekend when she last visualized it. RN-B stated she could tell something had been there referring to the previous blister but is was not open and not that big.

When interviewed on 10/25/18, at 11:30 a.m. RN-C stated being unaware R6 had an open area on his R inner buttock. RN-C stated the resident previously had a blister on his buttocks near the coccyx that was taken care of and to her knowledge the area had been doing better. RN-C reviewed the last skin assessment she had conducted in the electronic record dated 11/4/18;

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F 684	Continued From page 22 RN-C stated she had assessed the area since then on a paper form but was unable to locate at that time. RN-C thought the physician had been notified of the wound on the resident's buttock when it had opened but was unable to locate evidence as such. RN-C stated she had contacted the nurse practitioner earlier that day of the blistered area on R6's left heel that had been identified by the night shift last evening but did not about the resident's coccyx. RN-C confirmed the ombudsman volunteer was at the facility on 10/24/18 and shared that the resident was reporting pain she thought (the volunteer) might be related to sciatica. RN-C did not think the pain was related to the reddened area on R6's bottom as he had reported the pain as being "inside". RN-C further stated the director of nursing (DON) had talked with therapy about the pain R6 was describing; therapy had indicated they couldn't do anything about it if it was inside. RN-C then stated, "It's his anus that hurts apparently". RN-C confirmed she did not do a visual assessment of R6's bottom with the recent complaints of pain. When interviewed on 10/25/18, at 1:49 p.m. the DON stated if a resident had a new skin issue like a open slit in the coccyx area, they wouldn't necessarily contact the physician if they could manage the area on their own. DON stated when she talked with the ombudsman volunteer on 10/24/18, it sounded more like a muscular issue as the pain was described as going down his leg like sciatica. DON stated she had the resident see Occupational Therapy (OT) and also set up pain monitoring for the resident. DON indicated the resident had a PRN (as needed) Tylenol order that he hadn't been utilizing and encouraged the staff to offer if the resident complained of pain;	F 684		

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F 684	Continued From page 23 DON confirmed a visual assessment of the residents bottom had not been conducted when the ombudsman volunteer had shared the resident's complaints of pain. DON further confirmed she would have expected the nurse yesterday to pass on that R6 had an open area near the coccyx. DON stated she would set up an appointment with the physician to evaluate R6's open wound and also the complaints of internal pain. The Physician's Plan of Care and Discharge Orders dated 10/26/18, included: This is a pilonidal sinus tract (A pilonidal sinus (PNS) is a small hole or tunnel in the skin. It may fill with fluid or pus, causing the formation of a cyst or abscess. It occurs in the cleft at the top of the buttocks). It is draining. Does not require antibiotics or surgery. Cleanse with Dakins solution once daily. Apply silver Aquacel to base and cover with Mepilex. Report any additional swelling or increased redness of the site. Follow up visit in 2 weeks. The policy/procedure titled, Skin Assessment/Monitoring, revised 10/15, included to observe and chart on: b. Pain, if present; nature and frequency (e.g. whether episodic or continuous). e. Report to registered nurses any changes in wound characteristics. The policy/procedure titled Reporting Conditions to the Physician, dated 9/23/18, included: Protocol For - The charge nurse is responsible for immediately notifying the Physician, Nurse Practioner and family if the resident experiences a change in status, and has a reasonable potential for negative outcome, example include, but are not limited to:	F 684		

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F 684	Continued From page 24 - Any new pain or change in pain level that is not relieved with the use of ordered PRN medications. - Any signs or symptoms of an infectious process: redness, swelling, heat pain, drainage, urinary or respiratory symptoms etc.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement pressure relieving interventions for 1 of 1 resident (R22) reviewed who had a current facility acquired stage 3 pressure ulcer. The deficient practice resulted in actual harm for R22 when a stage 2 pressure ulcer worsened to stage 3. Findings include: Review of the current facility face sheet identified R22 was admitted to the facility on 8/23/18, with a	F 686	F686 1) R22 discharged to home on 10/29/2018. The matter of whether the pressure ulcer worsened or was staged incorrectly from the start is still unanswered for our care team. We are unable to provide irrefutable proof that this ulcer did not actually worsen. We believe that it was not staged correctly on 9/7. We have photographs capturing different points in time, but ulcers can□t be staged from a photograph retrospectively. We	12/4/18

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F 686 Continued From page 25

diagnosis of multiple sclerosis (MS).

R22's admission Minimum Data Set (MDS) dated 9/3/18, identified a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition, extensive assistance of staff with bed mobility and transfers, did not walk and was at risk for pressure ulcers/no pressure ulcers present. The MDS also identified R22 had pressure reducing devices for bed and chair, turning/repositioning program and applications of ointments other than to feet.

The Care Area Assessment (CAA) for pressure ulcers dated 9/5/18, identified R22 did not have any pressure ulcers present and was at risk for developing pressure ulcers related to requiring assist with ADL's (activities of daily living) and bed mobility as well as due to incontinence of bowel and being at risk for skin breakdown per assessment. R22 has diagnosis including multiple sclerosis (MS) and lower extremity spasticity.

R22's Braden (a skin assessment to determine risk for pressure ulcer) scale dated 8/24/18, identified risk factors including decreased sensory perception in fingers/toes, history of past pressure ulcers and can't raise legs in a straight position. The Braden identified a moderate risk for skin breakdown. R22 was identified as having very limited sensory perception with impairment limiting the ability to feel pain or discomfort in 1/2 of body, chairfast, moderate to maximum assistance to move, very limited mobility. The Braden scale completed 9/6/18, indicated R22 had additional risk factors including a sore present over left lateral malleolus and decreased sensory perception in fingers/toes. The Risk

F 686

believe that R22 was being appropriately cared for by the AMT Wound Nurse, the provider, and our nursing staff in a manner that would have led to complete healing and that this issue does not rise to the level of severity as assigned by the survey team.

2) 33 of 47 residents are at some level of risk for skin breakdown at the writing of this plan of correction. 27 residents are at mild risk like R22 was identified at on 9/6/18. Their situations are addressed on their care plans along with interventions to reduce the risk of breakdown. We recognize that our residents bear the right to choose to follow their care plans and may choose to live life taking more risks than recommended which could lead to negative outcomes such as skin breakdown.

3) We discovered that a step in our system was not in place for R22 which likely led to increasing the risk for her to develop the pressure ulcer. Re-education of the OT therapist was provided by the PT/OT supervisor, emphasizing the importance of providing the MDS Coordinator and the care staff the Communication Form as well as emphasizing the fact that it�s an error to assume that the care staff would automatically seek more information upon seeing new equipment in a resident room. Re-education was provided to the direct care team on November 29th to ask the Charge Nurse for details on how to apply and use new equipment that they may find

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F 686	Continued From page 26 score was identified as mild risk for skin breakdown. Sensory perception was identified as slightly limited, can't always communicate pain or need to reposition, chairfast, and moderate to maximum assistance to move. During observation on 10/23/18, at 1:55 p.m. R22 was sitting in dining room in wheelchair (w/c) playing BINGO. R22's was observed with their feet up on a foot board, which was on bottom of her wheelchair. R22's feet were resting directly on her footrests. R22 stated, "I have boots to wear when I am in the wheelchair but they don't stay on so I don't wear them." R22's left foot was rolled out and resting on the the left outer edge of the foot board and the bar for her leg rest, this area was in direct contact with the pressure ulcer on her foot. No pillows were under the feet, or protective boots to prevent pressure on the pressure ulcer site. During observation on 10/24/18, at 9:45 a.m. R22 was observed sitting in her w/c in her room. R22 stated she wore the heel boots when in bed. R22 stated she never wore foot boots at home and stated , "I didn't have all this stuff at home (foot board on leg rests). They put this on shortly after I got here." R22 stated when she was at home her legs dangled when sitting in her w/c, so there was no pressure on her feet. R22 stated, "I can't feel anything in my feet or legs so I don't know what is or where my foot is resting." R22 stated she wore the protective foot boots when in her bed and had feet up on a pillow when lying down. R22 stated she had never had a pressure ulcer on her foot before, and was unable to move her feet due to her diganosis of MS. R22 stated the facility was, "working with my w/c company to get something that will keep my legs and feet	F 686	in a resident□s room. By not asking the question in R22□s case, our entire team lost the opportunity to discover more quickly the lack of the Communication Form and to quickly implement the placement of equipment accurately as a way to reduce pressure. Lastly, a source of information could have been R22 as she was very easy to communicate with during her stay at this facility and was an accurate historian of information. We learned through interview prior to her discharge that she did not have a negative impact to her lifestyle as a result of the skin issue. Her overall impression of the care received was very positive and she has returned on several occasions to volunteer. 4) The MDS Coordinator and LPN who has received added training/education on wound care will continue to partner with the AMT Wound Nurse to manage these types of cases. They are the first line of communication to the rest of the care team and interdisciplinary departments. The DON and Administrator will be responsible for ensuring that the communication between the departments is timely and accurate and those departments are responsive with actions that work to promote healing, promote prevention, and respect personal choice of the residents. The DON will be adding skin issues/conditions to the regular QA agenda and the QAPI committee will continue to determine if a Performance Improvement Plan (PIP) needs to be initiated.	

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F 686	Continued From page 27 straighter." R22 She pointed at boots on the floor in room and stated that is the best that they have for me to use here. R22 was not wearing the protective foot boots at this time, and her foot was in direct contact with the footrest. At this time, a licensed practical nurse (LPN)-B performed a treatment to the pressure area. LPN-B asked R22 several times if the treatment to her foot hurt, and R22 responded, "I can't feel anything in my legs or feet." LPN-B confirmed R22's foot wound was now a stage 3 pressure ulcer. During the observation, an area was observed to the inner aspect of the right heel, which was very reddened and had a reddened, unopened area in the center. LPN-B stated R22 had this area before and it went away on its own. LPN-B called the director of nursing (DON) to room to observe area. LPN-B wrapped R22's right foot with ace wrap and put sock half way back on foot. No boots were put on R22's feet. At 10:07 p.m., R22 was observed sitting in the dayroom. The left foot (outer aspect where ulcer located) was noted to be resting on the foot board and support bar of her foot pedal. The inner aspect of R22's right foot remainded reddened in color. On 10/25/18, at 9:23 a.m., R22 was seated in her w/c in the activity room. At this time, R22 had protective boots on her feet. Review of the OT (occupational therapy) note dated 8/28/18, idenfied therapist noted R22's bilateral lower extremities (BLE) hanging off of foot rests upon approach and during evaluation. Therapies placed a footboard over leg rests to increase safety and decrease risk of pressure sores in fee and BLE. Review of the PT (physical therapy) note dated 8/28/18, idenfied consider splints for positioning of feet and ankles. OT note	F 686		

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F 686	Continued From page 28 from 8/29/18, identified patient had both feet placed on hard surface with pressure on the sides of feet, therapist at that time added labs wool to relieve pressure,and also discussed heel float boots to reduce pressure while in wheelchair and in bed. On 9/4/18, OT note identified therapist placed more cushioned board underneath R22's feet for extra support and education R22 on letting nursing know if it feels like there is too much pressure with new set up and have them remove. On 9/4/18, PT applied lateral thigh pads positioned to reduce abduction at the hips. On 9/5/18, OT contacted R22's wheelchair company to begin process of obtaining needed wheelchair positioning. On 9/6/18, PT documented R22 reported she had a sore on left lateral ankle. PT staff informed nursing. A 9/11/18, PT note identified staff repositioned feet in neutral position on foot plates. A 9/13/18, OT noted identified wheelchair specialist met with therapist and patient to complete seating assessment and make modifications to power wheelchair. R22 was educated on utilizing tilt on wheelchair to assist with pressure relief. It was recommended R22 have angle adjustable foot plates, shoeboxes, calf panel and larger 4x8 thigh pads to maximize overall position and prevent breakdown related to pressure. Review of R22's skin condition notes dated 9/6/18, at 10:39 a.m. identified R22 had received a shower in the a.m. Staff identified a quarter sized open area with little drainage noted to right inner ankle. Area was noted to be red with edema noted. A note dated 9/6/18, at 10:51 a.m. identified PT staff notified nursing that R22 had a sore present on left foot. Staff documented "because R22 has MS, her feet tend to lay naturally in a relaxed, unnatural position which	F 686		

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F 686	Continued From page 29	F 686		

results in her feet having in rolled outward appearance versus natural anatomic positioning." Staff noted open sore at the location of left lateral malleolus. R22 denied bumping, catching it on something or having something occur resulting in an injury to the area, however R22 has very little feeling in her fee/lower limbs related to MS diagnosis. Area was measured and cleansed with normal saline. Skin prep was applied to the periwound area and wound was covered with protective dressing.

R22's Wound care skin integrity evaluation, dated 9/6/18 identified a facility acquired, full thickness, unstageable (obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) to the left lateral malleolus. The pressure ulcer was described as 2.20 cm length by 2.10 cm width. Depth was undetermined, no tunneling or undermining was identified and drainage was serosanguinous. R22's PUSH (pressure ulcer scale for healing) was 11 (PUSH scores range from 1-17 with higher numbers being identified as worse pressure ulcers). Intervention was wound care with daily dressing change.

A physician's visit record dated 9/7/18, identified stage 2 pressure ulcer left lateral ankle. Orders included increase Furosemide (diuretic medication) to 60 mg daily, clean wound with safe cleans or similar, apply silver Aquacel over wound and cover with absorbent dressing. Measure wound/change dressing daily. Follow by wound care nurse.

A nurse practitioner (NP) note dated 9/12/18,

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F 686	Continued From page 30 idenfied ulcer to left ankle that had been evaluated, treatment to continue and see a wound nurse if wound doesn't respond to current treatment. A physician visit record dated 9/21/18, for check of left foot wound identified debridment of eschar (a piece of dead tissue that is cast off from the surface of the skin) from wound. Mild to moderate swelling over left ankle, 1.5 cm x 1.5 cm pressure ulcer on left lateral malleolus. Dry with dark colored eschar covering wound. Staff to continue with dressing changes recommended by wound care, consult wound care for re-evaluation. Little to no movement in bilateral lower extremities. Consult nutrition to see if they would recommend Arginine supplementation to help with wound healing. A follow up skin note dated 9/28/18, identified pressure ulcer as being reddened with dark center and some yellow/white tissue around outer edges of wound, light to moderate drainage and 2.5 cm by 2 cm. A wound skin integrity evaluation by the wound nurse dated 10/3/18, identified stage 3 (involves the full thickness of the skin and may extend into the subcutaneous tissue layer. At this stage, there may be undermining) pressure ulcer, 2.20 cm by 2.10 cm. Prevention provided: introduced turning/positioning schedule, routine skin assessments, use of pressure reduction/relieving devices, protective dressings. Treatment intervention: cleanse site per facility protocol. Pat dry. Apply skin prep to the surrounding skin and allow it to dry. Apply calcium alginate (cut to fit) the wound bed. Cover with absorptive dressing. Apply elastic bandage from the base of the toes	F 686		

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to just below the knee. Dressing change daily. Elastic bandage change every 23 days and as needed (PRN) for soilage. PUSH score 11.

A follow up skin note dated 10/12/18, identified stage 3 pressure ulcer, 2 by 1.5. Prevention provided: turning/positioning schedule, routine skin assessments (integrity and tissue tolerance), use of pressure reduction/relieving devices, protective dressings. Wound treatment unchanged from 10/3/18.

Skin note from 10/19/18, identified stage 3 pressure ulcer. Prevention provided: routine skin assessments (integrity and tissue tolerance), protective dressings. 2 cm by 1.5 cm with 0.4 cm depth.

Skin note from 10/24/18, right inner ankle/heel - 3.5 by 4 cm reddened area, with a 2 cm by 2.5 cm slightly raised area inside. Area cleansed, and left open to air.

R22's care plan for pressure ulcers dated updated 9/6/18, identified risk for skin breakdown. Sore present on left lateral foot. Interventions included keep heels elevated in bed, assist with positioning when in bed and in chair, avoid pressure on feet/ankles,protect feet/ankles with pillows as needed and dietary consult, provide nutritional supplement to promote wound healing as ordered. Increase protein in diet as appropriate to ensure adequate for wound healing and maximize oral intake. Monitor protein intake to ensure adequate amount for wound healing, maximize oral intake. The dietary care plan dated 9/11/18, identified potential for alteration in nutrition. Interventions included offer peanut butter at breakfast. The current NA

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F 686	Continued From page 32 (nursing assistant) care plan idenfied transfers with 2 assist, use hoyer lift, bed mobility with 1-2 assist, check for skin irritation around devices, position for comfort, assist with repositioning, use pillows for support, keep heels elevated in bed, avoid pressure on feet/ankles and protect fee/ankles with pillows as needed. During interview with R22 on 10/25/18, at 1:07 p.m. she stated I had those side board things in my chair tucked in the sides. They were trying to keep my legs from falling out. The guy that came for my wheel chair took them back to therapy. I haven't seen them since. He readjusted my chair and then I was lined up right. Since then I have pushed the sides of my chair back so it didn't work anymore. I have towels I could use but I don't because they push these things on my w/c back out. She stated they stay in for a little while but then they bow out again (legs). The towels don't help. The wheelchair guy was here in September. It was after I had the sore I think. He is getting me better stuff to protect my feet he called them shoe boxes. R22 stated she got the sore from the pressure of her foot resting on the board/leg rest. She stated when those side board things were in it made a difference my feet stayed on the board. She stated now my legs bow out again and my feet roll out and rest on the sides. During interview on 10/25/18, at 9:50 a.m. nursing assistant (NA)-G stated they tried those side board things in her chair a while ago but I haven't seen them for a long time. It might have been that she didn't like them. Now we put towels under her legs. They are supposed to keep her feet from rolling out. She doesn't have them in today though she told me she didn't want them. They are in the chair in her room. No	F 686		

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F 686		F 686		

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towels were found in the chair in her room.

During interview on 10/24/18, at 9:58 a.m. the certified dietary manager stated we usually do Arginaid until healed and one week post healing. She stated a dietary consult was not done when R22's pressure area was discovered and stated I will start the Arginaid today.

During interview on 10/24/18, at 10:00 a.m the dietician stated, "if a wound is a stage 2 or higher we would start the Arginaid." However, she stated no nutritional interventions were put into place.

During interview with registered nurse (RN) -D on 10/24/18 at 1:44 p.m. she stated, "We sent her to the Dr. the day after we found the pressure ulcer. The doctor said it was a stage 2 and a couple days later the wound nurse came and she called it unstageable. All of our mattresses are pressure reducing and she [R22] wears boots at night. We couldn't figure out what happened or caused it. [R22] is very delicate and can't feel her feet."

During interview with the physical therapy (PT) assistant PTA-A on 10/24/18, at 1:19 p.m. she stated, "OT (occupational therapy) has worked with her [R22] for positioning. They ordered some equipment that we needed a doctor's signature for. That is our foot board on her chair but I don't know for sure if the leg rests were on there before or not."
During interview on 10/25/18, at 9:45 a.m. OT-A stated R22 had been admittd with her legs dangling when in the wheelchair. OT-A stated, "She [R22] had foot rests however, her feet did not rest directly on the foot rests, they wer just dangling. We [OT] put everything on her chair that is on their now [footboard]. When we were

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F 686	Continued From page 34 seeing her, we had put lateral supports in the w/c to keep her legs in [to prevent them rolling outward]. However, now the supports are not in her chair nor are they in her room. The w/c guy has been here and might have taken them out, I'm not sure. Her positioning was way better when we were seeing her it was not like this (lateral foot resting on side of footboard/leg rest)." OT-A further stated R22 never refused anything they suggested for her care, and was always cooperative. During interview on 10/25/18, at 12:59 p.m. RN-D stated PT had provided documented recommendations on a sheet of paper which had been put on the floor for staff. RN-D stated she did not have any recommendations in her files from OT regarding positioning for R22. RN-D stated, "They [OT] did not give me anything or I would have it here." Regarding the wound RN-D stated, "I would say the ulcer is probably from the pressure of her foot laying on the side of the board." During interview on 10/25/18, at 10:15 a.m. OT-A stated, "Sometimes we write a note to nursing to communicate our recommendations. We are not very consistent with that. I don't think I wrote one regarding [R22's] positioning recommendations." When asked if there was no communication note how staff would know what recommendations to follow OT-A stated, "Well, they would see the stuff in her room and they are pretty good about using the stuff if it's in the room." During interview on 10/25/18, at 9:30 a.m. the director of nursing (DON) stated, "I saw the area the day therapy found it. It was acquired here as our initial assessment shows no open areas." The DON stated, "If [R22] was supposed to have lateral supports in her chair and they were not in her room, I would expect nursing to follow up on	F 686		

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F 686	Continued From page 35 why they are not being used. Any therapy recommendations should be on the care plan. I would agree she had pressure on her feet from them laying on the foot board and resting on the leg rest." The DON stated therapy should have sent a note to RN- D about their recommendations and what the staff were expected to do.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and ensure interventions were implemented to reduce the risk of falls for 1 of 4 residents (R32) who was reviewed for accidents. Findings include: R32's current diagnoses, according to the face sheet printed 10/25/18, included cerebrovascular (disease in which blood vessels in the brain are diseased causing decreased blood flow to the brain) disease, low back pain, right artificial hip joint, history of falling, atrial fibrillation (irregular heart beat), disorientation, macular degeneration (progressive vision impairment), sensorineural (inner ear or nerve) hearing loss, delirium	F 689	F689 1) R32 was hospitalized from 11/6 to 11/12 with pneumonia. A new assessment to determine risk for falls with injury will be completed along with the significant change MDS assessment. Care plan and interventions will be updated. Re-education of staff was completed on 11/12/2018. Resident enrolled in hospice services on 11/20/2018. 2) All residents of this care facility are assessed upon admission and at least quarterly, bearing the responsibility of	12/4/18

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	245522	A. BUILDING ______ B. WING ______	10/25/2018

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

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F 689	Continued From page 36 (serious disturbance in mental abilities) and vascular dementia (a condition caused by lack of blood flow to the brain) with behavioral disturbance. R32's quarterly Minimum Data Set (MDS) assessment dated 9/3/18, indicated a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS further identified R32 required extensive assistance of one to two staff members for transfers. R32's care area assessment (CAA) for falls, dated 3/20/18, indicated R32 was at risk for falls due to impaired balance and medication. R32's care plan, last reviewed 6/5/18, indicated R32 has a potential for trauma-falls injury related to gait/balance, hearing status, history of falls and medication and manifested by decreased mobility. Current interventions included: use of sensor alarm in wheelchair, bed, recliner, assist with ambulating, transferring, toileting, do not leave unattended when in bathroom, proactively promote comfort, instruct to call for help, keep personal items in reach, provide nonskid footwear, glasses on when up, bed in lower locked position. An event report dated 11/10/17, revealed: fall with lowering to the floor by staff from edge of bed. No apparent injury. No change in interventions or care plan. An event report dated 11/14/17, revealed: observed on floor sitting in the door to her room. No apparent injury. No change in interventions or care plan.	F 689	ensuring that they receive treatment and care according to provider orders, standards of care, and personal preference when possible and practical. This assessment includes areas of concerns related to pain, skin care, wound care, risk of injury from falls, etc. 3) The policy & procedure titled Resident Falls & Injuries was reviewed by the IDR Team and the team learned that interventions agreed upon during the post-fall assessment discussion were not being documented in the medical record or any other location which would have been helpful to show the progression of interventions being employed for R32. The team re-educated itself on the concept that our duty is not to prevent falls, but to reduce the risk of falls and to reduce the risk of injury associated with falls. We re-learned that the risk of falls is injury. Falling, in and of itself, is not always a problem. We recognized that we employed an incorrect perspective in R32□s care, focusing more on her family□s desire to prevent falls. Team discussion and agreements are documented as part of the post-fall assessment. 4) The IDR committee will continue to review the incident reports at their daily meeting, noting interventions and results. The Falls Committee will monitor the residents who are at high-risk for injury from falls which will include evaluating the interventions and making recommendations to the IDR such as to	

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F 689	Continued From page 37 An event report dated 11/22/17, revealed: found laying on left side on floor in front of recliner holding her forehead. No apparent injury. Reeducation of resident/family/staff included: continue to remind resident to use call light for assistance and not to attempt to stand up on her own. No change in interventions or care plan. An event report dated 11/26/17, revealed: lowered to floor from recliner footrest. Chair was tipped forward with resident sitting on footrest and resident sliding forward, so assisted softly lowering the rest of the way to the floor. No apparent injury. Reeducation included: reminding resident to use call light and not to attempt to stand up on her own. No change in interventions or care plan. An event report dated 12/1/17, revealed: fell forward out of wheelchair hitting head on floor. One centimeter laceration on forehead. Sent to urgent care for suture repair. No change in interventions or care plan. An event report dated 12/7/17, revealed: resident observed on floor bathroom. Left thumb bleeding which stopped with pressure and a Band-Aid. Interdisciplinary team (IDT) review stated they will obtain order for occupational therapy (OT) evaluation for self releasing belt. An OT treatment note dated 12/15/17, indicated use of Velcro belt with patient needing one verbal cue to remove before transferring. OT Treatment note dated 12/28/17, revealed a safety review with self release belt with patient and staff. Staff reports patient will remove belt independently.	F 689	change the care plan or modify an intervention. That committee will continue to escalate unresolved issues to QAPI and then the QAPI committee will decide if those cases should be developed into a Performance Improvement Plan (PIP).	

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F 689	Continued From page 38	F 689		

An event report dated 7/18/18, revealed: found sitting on the floor in front of her recliner. Call button out of reach. No apparent injury. Re-education included making sure call button in reach and alarm is plugged in. No new or change in interventions. Care plan updated was answered yes, however care plan last review date was 6/8/18.

An event report dated 10/17/18, revealed: heard bed alarm and found resident down on floor beside bed with body pillow. No apparent injury. Re-education included reminding resident to use call light when she needs help. No change in interventions or care plan.

During observation and interview on 10/23/18, at 1:32 p.m. R32 was in her room, removing her Velcro belt, attempting to get up, and hollering "help." Nursing assistant (NA)-A stated R32 will sometimes be in her room yelling. We put music on her television and she usually quiets down. If she doesn't we will take her to the bathroom.

During interview on 10/24/18, at 1:13 p.m. licensed practical nurse (LPN)-A stated they fill out incident reports at the time they occur and put immediate interventions into effect if there are any at that time to prevent further falls. LPN-A further stated sometimes there isn't anything new we can do so we report to the charge nurse and they discuss during daily conferences.

During interview on 10/24/18, at 2:30 p.m. Registered Nurse (RN)-A stated the director of nursing (DON), and nurse managers review every fall that happens in the building, complete a root cause analysis and try to come up with a solution. They jot down notes of their discussion, but there

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F 689	Continued From page 39 was no formal documentation. Notes from the IDT meetings were requested from 11/17 to present. One dated 12/7/17 was received for R32. During interview on 10/25/18, at 9:21 a.m. NA-B stated they checked on R32 every two hours. NA-B further indicated the care plan is where staff look for how often they should check on her. During interview on 10/25/18, at 10:19 a.m. RN-A stated we don't usually use Velcro belts but R32's daughter requested it. OT evaluated to ensure she can release it. It is part of her plan of care. Upon review of the plan of care, RN-A stated "I'm not seeing where it mentions the belt on her plan of care. I would think it should be there so we must have missed it." RN-A further indicated in the daily IDT meetings, they try to figure out what and why it happened and then put interventions into place. RN-A stated for R32 they increase safety checks to fifteen to thirty minute checks. She further indicated it is not part of the care plan and the documentation is done on paper and turned into the DON. During interview on 10/25/18, at 10:36 a.m. the DON stated if safety checks are implemented it should be placed on the care plan so it flows to the nurses aide kardex so they know to complete them. DON further stated the safety check sheets are turned into her and she keeps them for awhile but then discards them. Safety check sheets for R32's falls were requested and none were provided. The facility policy titled "Resident Falls and Injuries," not dated, included: RN managers will review the incident report, looking for root causes,	F 689		

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F 689	Continued From page 40 discussing possible interventions...Incident reports will also be reviewed at the next IDT meeting (Interdisciplinary meeting). RN manager will complete a Post-Fall Assessment and revise care plan as determined by and agreed upon by the care team and resident/responsible party.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to obtain a written contract between the dialysis provider and the facility for 1 of 1 residents (R3) reviewed for dialysis. This had the potential to affect all residents who received dialysis treatments and resided at the facility. Findings include: R3's face sheet dated 10/25/18, identified diagnosis of chronic kidney disease. R3's quarterly Minimum Data Set (MDS) dated 10/7/18, identified R3 received dialysis. R3's care plan last revised 9/17/18, included dialysis care. On 10/25/18, at 2:55 p.m. the director of nursing (DON) stated the facility did not have a contract or current written agreement with the dialysis	F 698	F698 1) The written contract was received by our facility on November 19th from the dialysis provider and placed on file for R3. 2) There are no other current residents with orders for dialysis services. 3) The DON and Administrator will review the Requirements of Participation (RoP) to verify what is required as it relates to residents receiving dialysis services. 4) The DON and Administrator will be responsible for ensuring that the RoPs are in place and compliant.	12/4/18

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F 698	Continued From page 41 facility for coordination of services. The DON stated the facility had residents in the past who required dialysis treatments but it had been several years. A facility policy on dialysis was requested, but none was provided.	F 698		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		11/28/18

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F 880	Continued From page 42 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure visitors and	F 880	F880	

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F 880	Continued From page 43 residents were alerted of special contact precautions for 1 of 1 resident (R196) reviewed and diagnosed with clostridium difficile (C-diff). This has the potential to affect visitors who fail to implement proper contact precautions. Findings include: R196's diagnosis list dated 10/25/18, included enterocolitis (inflammation of small intestine and colon) due to C-diff. R196's admission Minimum Data Set (MDS) assessment dated 10/19/18, identified R196 with a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS further identified R196 as needing extensive assistance with activities of daily living (ADL's) and frequent incontinence of both bowel and bladder. R196's care plan dated 10/16/18, indicated the resident had a C-diff infection and required contact precautions. During the initial tour on 10/22/18, at 3:33 p.m. it was noted there was no signage to indicate to staff and visitors that R196 required any special contact precautions, however the facility matrix identified R196 was on transmission based precautions. During interview on 10/23/18, at 2:39 PM nursing assistant (NA)-C stated R196 was on contact precautions, but was unsure how visitors would know this, verifying there was no signage on R196's doorway. During observation and interview on 10/25/18, at	F 880	1) R196 discontinued Transmission-Based Precautions on 10/30/18 2) There are no residents in-house currently requiring Transmission-Based Precautions. 3) The policy titled Infection Control was revised to add, A sign will be posted outside the resident□s door alerting staff, visitors, and others to see the nurse prior to visiting. under the section labeled Transmission-Based Precautions. 4) The DON will continue to be responsible for ensuring that the protocols for communicating transmission-based precautions to all staff and visitors is being followed in each case. Re-education will be provided to the licensed nurses about the policy update and when to apply the sign to affected residents□ doors.	

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F 880	Continued From page 44 9:11 a.m. registered nurse (RN)-C verified there was no signage on R196's room door to indicate to visitors of any special contact precautions required and/or directions to see the nurse prior to entrance. RN-C stated though staff are all aware, there should be an alert to visitors and others entering the room. During interview on 10/25/18, at 10:17 a.m. the director of nursing (DON) confirmed R196 was on contact precautions for C-diff. The DON further verified there was no signage on the entrance to R196's room to indicate visitors should check with the nursing staff stating, "he should have that". A facility policy titled, Infection Control, dated 11/2017, indicates type and duration of isolation precautions will be on a case by case basis following current CDC guidelines.	F 880		

F5522029

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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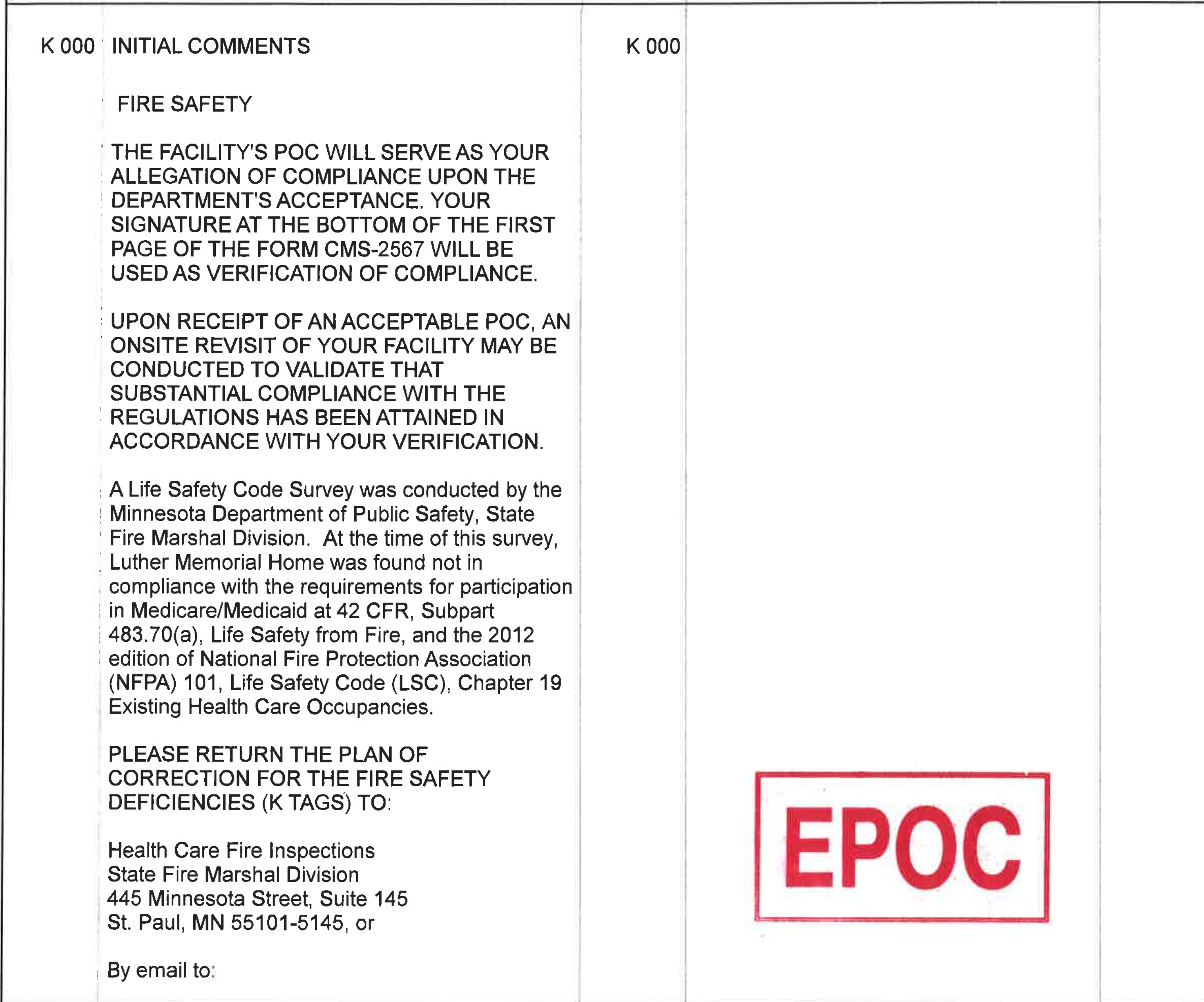

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Luther Memorial Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Luther Memorial Home was constructed as follows: The original building was constructed in 1958, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st addition was constructed in 1973, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 2nd addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The 3rd addition was constructed in 2001, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has a fire alarm system with smoke detection throughout the corridor system. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 50 at time of survey.	K 000		

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914	K914 The non-hospital rated electrical outlets in resident rooms will be inspected and tested. Outlets that fail the test will be replaced. The Environmental Services Director will be responsible for ensuring that the	12/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/24/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 3 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). This deficient practice could effect 50 out of 50 Residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 10/24/2018, during documentation review and interview, documentation could not be located to show that the non-hospital rated electrical respectables within the resident rooms are tested at intervals not exceeding 12 months. This deficient practice was verified by the Facility Maintenance Director.	K 914	testing is completed and put on an annual schedule. Completion Date: December 4, 2018	
K 926 SS=D	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.	K 926		12/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/24/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 4 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. This deficient practice could effect 50 of the 50 residents. 11.5.2.1 (NFPA 99) FINDINGS INCLUDE: Based on observation and documentation review,between 9:00 AM and 12:00 PM on 10/24/2018, documentation could not be located to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders per NFPA 99. This deficient practice was verified by the Facility Maintenance Director.	K 926	K926 An online class titled "Oxygen Safety" was added as an all staff assignment through Relias Learning on 10/24/18.. An inservice for staff who handle the oxygen cylinders will be provided by our O2 vendor as soon as vendor can arrange an appointment. The DON and Environmental Services Director will be responsible for ensuring that training is offered to newly hired employees at orientation and all other staff at least biannually. Completion Date: December 4, 2018	