STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355084	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN SUNSET HOME	333 EASTERN AVE GRAFTON, ND 58237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/19/18 and concluded on 07/20/18.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2018

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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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to ensure one of 17 sampled residents (Resident #64) had a clean room free from ants. Findings include: Observation on 07/19/18 at 9:45 a.m. revealed several live ants on the bedside table next to the recliner chair in Resident #64's room. On 07/20/18 at 10:04 a.m., a red ant was observed crawling on Resident 64's bedside table. Several more ants were crawling on the floor next to the bedside table. Small corn chip pieces were observed on the floor next to the recliner chair. Grime and crumbs were observed in the corner of the room near the sink. White specs of debris were noted on the area rug in the center of the room. A staff nurse (#90) was in Resident 64's room at the time of the observation and confirmed that she saw the ants crawling on the floor. During an interview with a housekeeping staff member (#54) on 07/20/18 at 10:15 a.m., she stated that she has seen ants in Resident 64's room, but not recently. The staff member stated	F 584	Thorough cleaning of the effected room was completed on 7/19/18 and ants were removed at this time. Effected room was added to facility cleaning schedule to ensure that the room is cleaned thoroughly and on a routine basis. Effected room will have an intensive cleaning bi-monthly. Facility cleaning list was compared to current census report to ensure that all occupied rooms are included and being cleaned routinely. Facility□'s cleaning program has been modified and renamed to reduce confusion and ensure that all rooms are being cleaned thoroughly and on a routine basis. "Thorough cleaning" is defined as a cleaning of the bed, dresser, night stand, garbage cans, mop boards, furniture, and window ledge. In-service will be held with all housekeeping staff on 8/9/18 to train on updates to the cleaning program. Education on pest prevention will also be provided for housekeeping personnel at this in-service.	

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F 584	Continued From page 2 she has not seen ants in any other resident rooms. On 07/20/18 at 11:15 a.m., a Maintenance Supervisor (#8) was interviewed regarding the cleaning of resident rooms. The Maintenance Supervisor (#8) stated rooms are cleaned daily by housekeeping. In addition, every month a "bed wash" is done on every room in the building. The Maintenance Supervisor (#8) explained a bed wash was a deep cleaning and includes washing every surface of the bed, washing the bedside table, wiping all items in the room thoroughly, washing the garbage pail, mopping the baseboards, and cleaning behind furniture. The Maintenance Supervisor (#8) stated Resident #64 does not have a bed in her room, so she does not show up on the list for a bed wash (deep clean). The Maintenance Supervisor (#8) said there is no documentation that Resident #64's room has had a deep clean and they do not have a policy and procedure for deep cleaning. Bed wash records dated January 2018 - June 2018 were reviewed. These records indicated that a bed wash was not conducted in Resident #64's room in the past six months. On 07/20/18 at 12:06 p.m., a housekeeping staff member (#117) was interviewed about the bed wash process. The staff member (#117) stated once a month everything in a resident's room is pulled out, wiped and washed. The staff member (#117) said, "It's been a while since I deep cleaned [Resident #64's room]. Deep cleaning is done by bed wash lists. If it's not on the list, we only would do it if the Certified Nursing Assistant (CNA) asks us to do it."	F 584	Environmental Supervisor, or designee, will monitor facility cleaning schedule every other week to ensure that rooms are being cleaned thoroughly at a minimum of once each month. Audits will begin on 8/17/18. Results of these audits will be reported to the QA committee on a quarterly basis for at least one year with a goal of one hundred percent compliance.	

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F 584	Continued From page 3 On 07/20/18 at 12:37 p.m., a housekeeping staff member (#139) was interviewed regarding Resident #64's room. The staff member (#139) stated there are a lot of spills and food on the floor in Resident #64's room. The staff member (#139) stated Resident #64 doesn't have a bed so she's not on the bed wash list. An Ecolab report dated 07/12/18 documented ants were observed and treated in Resident #64's room.	F 584		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;	F 838		8/24/18

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F 838	Continued From page 4 (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 838	Interdepartmental team will develope a	

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F 838	Continued From page 5 facility failed to conduct a facility-wide assessment to evaluate the resident population and identify the resources needed to provide care and services to residents competently during both day-to-day operations and emergencies. This had the potential to affect all 85 residents currently residing in the facility. Findings include: On 07/19/18 at 8:45 a.m., a request was made for the Facility Assessment during the entrance conference conducted with the Administrator and the Director of Nursing (DON). A second request was made for the Facility Assessment on 07/20/18 at 2:30 p.m. during an interview with the DON. She indicated the Administrator had already provided this information; but she would follow up with the Administrator and ensure the required information was provided to the survey team. On 07/20/18 at 3:40 p.m., the Administrator came into the conference room and shared that he had left a manual in the conference room that included the Facility Assessment. Review of this manual revealed an assessment of the physical building of the nursing home. There was no Facility Assessment of the resident population to identify the resources needed to provide care and services to residents on a day to day basis and in an emergency. Further interview with the Administrator at this time revealed he was not aware of what was being requested as he was not familiar with the Facility Assessment. He verified on 07/20/18 at 3:45 p.m. that he did not have a Facility Assessment to provide to the survey team. He stated that he was unsure of	F 838	facility assessment in accordance with regulations by 8/13/18. All facility residents have the potential to be impacted by this alleged deficiency. An all staff in-service will be held on 8/14/18 to educate staff on facility assessment and receive input of frontline staff in its development. Nurse meeting will be held on 8/16/18 for nurse specific training and feedback involving the facility assessment. Board of Directors will review facility assessment on 8/23/18 at the monthly board meeting. Facility assessment will be reviewed by board of directors and quality assurance committee annually and upon any significant changes in operations and the assessment will be updated as necessary.	

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F 838	Continued From page 6 what was required for the Facility Assessment.	F 838		