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 _____	09/19/2013

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 For the standard Medicare/Medicaid recertification survey started on 09/16/13 and completed on 09/19/13, the sample included 4 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000	Preparation and submission of this plan does not constitute an admission or agreement by the Lutheran Sunset Home of the truth of the facts alleged and shall not be construed in any administrative or judicial form for the purpose of establishing liability of our facility, it's Board of Directors, administration, employees or representatives. This plan is our allegation of substantial compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the	F 280	Indwelling urinary catheter was added to resident #15's care plan 9-27-2013 along with goals for its use and approaches for care. Approaches no longer applicable were removed. Risk for Elopement was added to resident #9's plan of care 9-18-2013. The care plan also contains goals and approaches associated with the risk. New admissions may have needs/risks not immediately evident on admission. Residents re-admitted to the facility after a hospital stay may have a change in condition that requires an adjustment to their planned care. Residents fitting this criterion have had their care plans reviewed for omissions of and/or presence of approaches no longer relevant to their care. Nurses were reminded to enter all changes in the resident's care into their care plan at the nurses meeting on 10-17-2013. Care plans for residents newly admitted or re-admitted will be reviewed within one week of their due date to assure it contains current approaches and is inclusive of identified risks/needs. The reviews will be conducted by the DON (Director of Nursing) or her/his designee. Reviews will continue monthly until 100% compliance has been met. Then reviews will be completed quarterly for one year to assure compliance is maintained.	11/4/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Eilson | TITLE: CEO | (X6) DATE: 11/18/13

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
	355084	A. BUILDING _____ B. WING _____	09/19/2013

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 280	Continued From page 1 residents' status for 2 of 16 sampled residents (Resident #9 and #15). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #15's medical record occurred on September 18-19, 2013. Medical diagnoses included urinary retention. Resident #15's quarterly Minimum Data Set (MDS), dated 07/11/13, identified an indwelling foley catheter in Section H. A physician's order, dated 06/26/13, identified an indwelling catheter. Observation on 09/18/13 at 4:45 p.m. showed a certified nurse aide (CNA) (#9) emptied Resident #15's urinary catheter leg bag. Resident #15's current comprehensive care plan identified the following: "Problem - Potential for altered urinary elimination related to BPH [benign prostatic hypertrophy]" with approaches of " . . . Monitor for increased symptoms of BPH such as: urinary frequency, urgency, voiding at night, urinary stream hesitency [sic], intermittency, straining to void, and dribbling. . . ." Resident #15's current care plan failed to identify the use of an indwelling catheter and the approaches necessary to care for Resident #15's indwelling catheter. During an interview on 09/19/13 at 8:55 a.m., a nurse manager (#3) confirmed Resident #15's current care plan failed to address the use of an indwelling catheter. - Review of Resident #9's medical record	F 280		

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 _____	09/19/2013

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 280	Continued From page 2 occurred on September 16-19, 2013. Medical diagnoses included dementia and depression. Resident #9's admission MDS, dated 08/13/13, identified moderately impaired cognition with supervision and set up assist for locomotion on the unit and limited assistance of one person for locomotion off the unit. Resident #9's interdisciplinary progress notes identified the resident eloped from the facility on the following four occasions: *08/20/13, 1:20 p.m. - "Resident found outside . . . he [resident] states 'I went outside cause it looked nice out then it got hot, so I came back in. . . ." *08/27/13, 8:30 a.m. - "Resident was found outside through door #12 out on the street with wheeled walker. Resident states, 'I was just getting some air.' . . . Resident states, 'I was looking for [daughter's name].' Writer asked resident "What made you think [daughter's name] would be out on the street? Resident states, 'She is always out here. . .'" *08/27/13, 10:30 a.m. - ". . . Durable Power of Attorney [DPOA] . . . agreed to placement of wander guard." *08/31/13, 10:45 a.m. - "Resident found outside sitting on bench by . . . door. Resident had everything is his room packed. Resident stated, 'I needed some fresh air. . . ." *08/31/13, 7:30 p.m. - "Door alarms sounded and found resident outside of door # nine. . . " Resident #9's current comprehensive care plan dated August 2013 failed to identify elopement as a problem and the approaches for addressing the problem, including a wander guard. During an interview on 09/17/13 at 3:20 p.m., a	F 280		

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 _____	09/19/2013

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 280	Continued From page 3 Licensed Social Worker (#1) confirmed staff should have updated the care plan to reflect Resident #9's elopement behavior.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 1 of 5 sampled residents (Resident #1) with wandering behaviors. Failure to thoroughly assess the residents' behaviors, implement individualized interventions, and establish on-going monitoring of the behaviors may result in decreased physical, mental, and psychosocial well-being and may negatively impact residents' quality of life. Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included dementia, encephalopathy with agitation and restlessness, and a history of stroke. The current Minimum Data Set (MDS), dated 07/31/13, identified short and long term memory problems,	F 309	Resident #1 is not currently utilizing the Merry Walker. A Behavior Assessment was started 10-28-2013. After completion of the assessment a behavior intervention plan will be drafted. All residents that trigger for wandering on their most recent MDS have had their care plans assessed for individualized interventions to meet their need(s) that may precipitate the wandering behavior. Review of Policy and Procedure(s) related to resident behavior are being reviewed, and revised if needed to assure that the assessment of resident behavior leads to individualized interventions which have the potential to reduce and/or alleviate the behaviors causative factors. Staff will be instructed on any changes to the Policy and Procedure. Staff has been receiving ongoing dementia care training with a series of videos entitled Hand and Hand. The series began 4-9-2013 the most recent video training was provided 10-8-2013, titled "Being with a Person with Dementia – Listening and Speaking". A mandatory training for all nursing, activity, maintenance, and transportation staff will be provided October 31, 2013. A generalized review of unmet physical and/or psychosocial needs that may precipitate behaviors will be presented. In addition some resident specific behaviors and interventions will be discussed. The training will be presented by the DON and Social Services. Twenty-five percent of residents experiencing wandering behavior will have chart reviews monthly for compliance with facility policy and procedure for development of behavior interventions until 90% compliance has been	11/4/13

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 _____	09/19/2013

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 309	Continued From page 4 moderately impaired daily decision making skills, and wandering which occurred daily. Current medications included Ativan (an antianxiety medication) 1 milligram [mg] three times per day and Seroquel (an antipsychotic) 25 mg in the morning and 100 mg in the evening. Resident #1's current care plan stated, ". . . Has short attention span, unable to focus on task/activity for very long. Requires continual supervision and verbal assistance with every task. . . . Approaches . . . Provide [Resident #1] with 1:1 programing [sic]. Keep his hands busy. Was a bulk truck driver. . . . Behavior: Dx [diagnosis] of anxiety, restless and fidgety, crawls out of w/c [wheelchair] and bed onto floor, some wandering up and down hallways . . . Approaches . . . Ativan and Seroquel as ordered . . . Offer activities that may help [Resident #1] relax . . . Merrywalker to allow [Resident #1] to stand [and] walk on own [with] supervision . . ." Interdisciplinary progress notes stated the following: *06/06/13 at 6:00 p.m.: ". . . He is in merriwalker [sic] wide awake, ambulating in hallway [with] staff in work area. Resident does move et [and] pull on the protective bar in front et often is looking at the seat belt. . . ." *06/07/13 at 11:00 a.m.: ". . . Resident went into another resident's bathroom [and] undressed [and] pulled apart the catheter [his own]. Was able to redirect [and] redress him. . . ." *06/08/13 at 12:40 p.m.: ". . . Resident @ dinner table wanting to stand up. Staff near him encouraged to sit down [and] finish eating, turns whispers to CNA [certified nursing assistant], 'I got to go to the bathroom.' Resident assisted to toilet per [2 staff assist] et walker from w/c	F 309	met. These reviews will be conducted by a social worker not responsible for that residents care. After compliance is met reviews will be completed quarterly for one year to assure compliance is maintained.	

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 _____	09/19/2013

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 309	Continued From page 5 [wheelchair]. Had normal BM [bowel movement]. . . ." *06/17/13 at 10:45 a.m.: ". . . Laundry dept. [department] noted Res. [resident] in Merrywalker tipped onto Rm [room] #22 bed et CNA informed writer. Res. was sitting in Merrywalker that was tipped against bed in Rm 22. Asked [Resident #1] if he was trying to lay down in the bed et Res. stated, 'I was going to lay down.' Merrywalker was tipped back to sit on all 4 wheels et Res. was lowered to the floor. . . . Res. put in bed after incident et went right to sleep. Educated staff to make sure Res. is supervised at all times when in Merrywalker et plan is to have PT [physical therapy] assess Res. in Merrywalker again. Res. had just been up at nurses station visiting [with] nurses prior to incident. . . ." *06/20/13 at 11:45 a.m.: ". . . Resident has been up ad lib [as desired] in hallways in Merriwalker [sic], has had nursing services observing activity - resident has opened Merriwalker [sic] safety belt et safety bar 5 times in past 1/2 hour. . . ." *06/21/13 at 9:30 a.m.: ". . . Resident was found with [merry] walker leaning against bed. When asked what he was doing trying to lay down [sic]. . . ." *06/21/13 at 2:15 p.m.: ". . . Follow-up unobserved fall from 6-19-13. Writer was walking by library et saw Res. sitting on floor in front of Merrywalker. Res. had unbuckled strap on Merrywalker. . . . Follow-up near fall from 6-21-13. CNA's were passing by Res. room et saw Res. in Merrywalker tipped over onto Res. roommates bed. Res. was still straped [sic] into Merrywalker. Res. said to CNA's 'I want to lay down.' . . . Staff educated that Res. needs supervision when in Merrywalker et if Res. appears tired to lay down in bed. . . ." *06/29/13 at 12:30 p.m.: ". . . Resident was sitting	F 309		

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 _____	09/19/2013

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 309	Continued From page 6 in Merrywalker by sun room door just looking outside. Then door alarm sounded, staff rushed to sun room, resident had pushed door hard enough to open door and was sitting half way in the doorway. When asked what he was doing he stated 'I want to go outside.' Got resident turned around and back inside. . . ." A facility form titled "Cognitive/Behavior Log" for the month of September 2013 identified Resident #1 wandered during at least one shift per day on 12 of 18 days. These forms lacked specific information as to Resident #1's wandering which would enable staff to track and trend the behaviors, determine patterns, and identify possible causative factors. The monitoring record failed to identify approaches/interventions attempted by staff, and failed to include possible causes for wandering (i.e. looking for the bathroom, a place to rest, hunger, boredom, etc.) A random observation on the morning of 09/17/13 showed Resident #1 ambulating in the Merry Walker and entering another resident's room. An unidentified CNA stated, "That's not your room," and directed Resident #1 back into the hallway. An observation on 09/17/13 at 10:27 a.m. showed Resident #1 ambulating in the Merry Walker and entering another resident's room. A CNA (#8) stated, "No, [Resident #1]. That isn't your room. Come out here." The CNA then guided Resident #1 out of the room and into the hallway. The CNA failed to assess Resident #1 for unmet needs and/or attempt to determine causative factors for the resident's wandering behavior (i.e. a need for toileting, rest, activity, due to hunger/thirst, etc). Resident #1's care plan failed	F 309		

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 _____	09/19/2013

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 309	Continued From page 7 to identify specific interventions to address the wandering behavior, and monitoring logs failed to identify patterns, possible causes, and interventions attempted in order to adequately assess Resident #1's behavior. During an interview on the morning of 09/19/13, a supervisory nursing staff member (#3) stated she has instructed staff to assess Resident #1 for unmet needs if they see him wandering and agreed the care plan lacked specific interventions to address wandering behaviors.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary interventions (i.e. heel boots) to prevent the development/reoccurrence of pressure ulcers for 1 of 2 sampled residents (Resident #1) with a history of pressure ulcers. Failure to implement preventative measures may result in a reoccurrence of Resident #1's heel pressure ulcer.	F 314	Resident #1 has bilateral heel boots. He/she wears them when in bed. Observations of all residents that require heel boots for pressure relief are being conducted both during naps and nighttime sleep. Nursing staff were reminded of the need to always provide recommended pressure relieving devices during a mandatory in-service 10-31-2013. Monthly reviews of all residents requiring heel boots will be completed during naps and nighttime sleep to assure their use. After two consecutive months of 100% compliance the reviews will be reduced to every six months for one year to assure continued compliance. The reviews will be completed by the DON (Director of Nursing) or her/his designee.	11/4/13

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 _____	09/19/2013

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 314	Continued From page 8 Findings include: Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a history of a right heel pressure ulcer. A "wound care flowsheet" identified Resident #1 developed an unstageable heel pressure ulcer on 04/17/13, and the ulcer healed on 05/21/13. Resident #1's care plan and CNA flowsheet both identified bilateral heel boots to be worn when in bed. Observation on 09/17/13 at 12:57 p.m. showed two CNAs (#8 and #13) assisted Resident #1 to lie down in bed. A licensed nurse (#14) indicated she needed to check Resident #1's heels. She stated, "You can see where his pressure sore was," and pointed to a pink, scarred area on Resident #1's right medial heel. The nurse then stated, "I think he has heel boots." The nurse applied one heel boot to the resident's left foot, but failed to locate a heel boot to place on his right foot. Observation showed Resident #1 remained in bed until 3:31 p.m. when two CNAs (#9 and #10) assisted him out of bed. Observation on 09/18/13 at approximately 1:00 p.m. showed Resident #1 asleep in bed without heel boots on either foot. Resident #1 remained in bed without heel boots, with heels resting directly on his mattress, until approximately 3:30 p.m. when staff members assisted him out of bed. During an interview on the morning of 09/19/13, a supervisory nurse (#3) stated she would expect staff to find another heel boot for Resident #1's	F 314		

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 _____	09/19/2013

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 314	Continued From page 9 right foot and that it is important to wear them given the resident's history of a pressure ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's user instructions, and staff interview, the facility failed to ensure the safety of 1 of 1 sampled resident (Resident #8) and 1 of 1 supplemental resident (Resident #21) observed transported in the facility vans. Failure to safely position and secure residents in a facility van during transport may result in bodily injury. Findings include: Review of the manufacturer's user instructions for "Q'Straint Wheelchair Passenger Safety Solutions" occurred on the afternoon of 09/18/13. These instructions provided by a maintenance staff member (#4) stated, ". . . WARNINGS: Systems should only be used with forward facing wheelchairs . . . Systems are dynamically crash tested to 30 mph [miles per hour] . . . using an . . . Anthropomorphic Test Dummy [ATD]. The ATD is restrained by both lap (pelvic) and shoulder (upper-torso) restraints; use of only a lap restraint	F 323	The medical condition that caused resident #21 to refuse the shoulder belt has been resolved and he/she has agreed to wear shoulder belt in the future. Additional equipment has been ordered to relieve pressure caused by the shoulder harness due to medical concerns. The equipment complies with the current safety restraint manufactures specifications. Facility policy and procedure has been developed for the transportation of any/all residents using a facility owned motor vehicle(s) and complies with the safety restraint manufactures specifications. All transportation staff have been giving hands on instruction in the procedure, and have been provided a copy of the policy and procedure on October 29, 2013. Residents using motor vehicle transportation provided by Lutheran Sunset Home must comply with all safe procedures established by policy. Ten percent of all weekly motor vehicle transports will be observed. Observation will include loading the resident into the vehicle and securing safety restraints for the individual and/or the mobility device used by the individual until 100% compliance with the policy is established for two consecutive weeks. Then five percent of all transports via a motor vehicle will be assessed monthly for one year to assure continued compliance. Monitoring will be completed by the Housekeeping/Laundry supervisor, the Maintenance supervisor and/or the Activity Director.	11/4/13

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 _____	09/19/2013

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 323	Continued From page 10 may compromise the performance of the system. . . ." Observation on 09/17/13 at 10:10 a.m. showed a transport aide (#5) wheeled Resident #8 in her wheelchair into a tan facility van. The transport aide positioned the resident's wheelchair behind the driver's seat and facing the van's left driver's side window. The transport aide (#5) secured the wheelchair to the floor of the van with a four point attachment securement system. The transport aide then placed and buckled a seat belt across the resident's lap in the wheelchair. The transport aide (#5) failed to apply an upper torso belt. Observation on 09/19/13 at 8:50 a.m. showed a transport aide (#6) wheeled Resident #21 in her wheelchair into a white facility van. The transport aide (#6) secured the wheelchair to the floor of the van with a four point attachment securement system. The resident stated she would like to only use the lap belt. The transport aide then placed and buckled a seatbelt across the resident's lap in the wheelchair. The transport aide failed to educate the resident regarding reduced safety with only the lap belt.The transport aide (#6) failed to apply an upper torso belt. During an interview on the morning of 09/18/13, an administrative activity staff member (#7) stated, "most all the residents face forward" during van transports in their wheelchairs. The residents facility staff turns sideways depends on the size of their wheelchair. Residents in reclining or electric wheelchairs are turned sideways during van transports. An administrative activity staff member stated the facility trains transport aides using demonstration and there is no written procedure.	F 323		

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 _____	09/19/2013

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 323	Continued From page 11 When interviewed on 09/18/13 at 1:15 p.m., a transport aide (#6) stated if the resident's wheelchair has footrests then the resident is turned sideways during van transports. The transport aide also stated he turns electric wheelchairs and large-sized wheelchairs sideways during van transports. During interviews on the morning of 09/18/13 and the morning of 09/19/13, a transport aide (#5) stated she had not been aware of manufacturer's user instructions on securing residents during van transports. During interview on the morning of 09/19/13, an administatrive staff member (#12) confirmed the white van had the "Q'Straint Wheelchair Passenger Safety Solutions" system and stated the safety system in the tan van was unknown. Failure to face the resident forward and apply a shoulder restraint during van transports as directed by the manufacturer's user instructions for the safety system may compromise the performance of the system and place residents at risk for potential injury or harm.	F 323		
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the	F 494	All agency staff has had their certification verified. The facilities process for Certified Nurse Aide registry verification will only be completed with the individual's social security number being the identifier. The Personnel Policy "Hiring Process" has been changed to reflect this. Monitoring will be completed monthly to assure all certification verifications have been completed using the potential employee's social security number. After 100% compliance has been meet monitoring will be completed quarterly for one year to assure sustained compliance.	11/4/13

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 _____	09/19/2013

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 494	Continued From page 12 requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on review of the state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure 1 of 3 traveling nursing assistants (Agency Staff #1) working with residents in the facility remained certified. Agency Staff #1 provided 265 hours of nursing related services without the facility verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: Information from the North Dakota nurse aide registery identified Agency Staff #1's nurse aide certification expired on 1/23/13. Review of employee files on 09/17/13 at 5:00 p.m. with an administrative staff member (#15)	F 494		

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 _____	09/19/2013

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 494	Continued From page 13 revealed Agency Staff #1's certification expired on 01/23/13. This nursing assistant worked with residents in the facility without certification for a total of 265 hours between 1/23/13 and 04/30/13. During an interview on the afternoon of 09/17/13, an administrative staff member (#15) verified Agency Staff #1's certification expired and the facility's process failed to identify the expired certification.	F 494		