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 _____	10/20/2010

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 10/18/10 and completed on 10/20/10 the sample included 5 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff assisted residents with activities of daily living in a manner that preserved and enhanced resident's dignity for 1 of 7 sampled residents (Resident #1) assisted with toileting and 2 supplemental residents (Residents #21 and #22) assisted during dining. Findings include: - Observation on 10/19/10 at 9:40 a.m. showed a CNA (#8) assisted Resident #1 to the bathroom shared with other residents. Observation showed a toilet riser positioned on the toilet seat with dried stool on the top and sides of the seat. Observation showed Resident #1 sat on the toilet seat allowing skin to come into direct contact with the dried stool. When finished the CNA (#8) assisted the resident to her chair and left the room. The CNA failed to clean the toilet seat	F 241	Resident #1 bathroom was cleaned 10/19/10. The process for cleaning soiled toilets between routine housekeeping is being reviewed. Resident # 21 and # 22 nasal hygiene is being cared for in a dignified manner at all times including during meal consumption. Cloth and/or paper napkins are being used to remove food particles from their lips during meal consumption. Residents that require assistance with meal consumption are being observed during meal time to assure their dignity is maintained. A brief oral review of facility processes affecting the care described above was provided to on duty staff 10/20/10. Individual meetings were held with those involved in the incidents. In-service training for nursing and dietary staff will be provided 11/16/10. QA (Quality Assurance) studies will be completed weekly under the direction of the DON (Director of Nursing) until compliance is achieved. After compliance has been achieved, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained.	11-24-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rodney Olmo, CEO	Dir. Exec. Officer	11-9-10

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 241	Continued From page 1 before leaving the room. The staff member failed to preserve Resident #1's dignity by allowing her to sit on a soiled toilet seat. - On 10/19/10 at 12:05 p.m., observation showed a Certified Nursing Assistant (CNA) (#6) feeding Resident #22 in the dining room. A large amount of mucus hung from the resident's nose to his chest. The CNA continued to feed the resident numerous spoonfuls of food around the nasal discharge and failed to clean the resident's face for several minutes. - Observation on 10/19/10 at 12:10 p.m., showed two CNAs (#5 and #6) assisting Resident #21 with dining. The resident was observed to have nasal discharge dripping from the end of his nose. One CNA (#6) continued feeding the resident without wiping the discharge from his nose. The other CNA (#5) wiped food from the resident's mouth and chin using the clothing protector worn by Resident #21. The CNAs failed to wipe the resident's nose with a tissue and clean the resident's face with the cloth napkin provided at the table. An interview with an administrative nursing staff member (#4) occurred on 10/20/10 at 10:45 a.m. The staff member agreed the CNAs (#5 and #6) should have wiped Resident #21 and 22's noses immediately with a tissue and CNA (#5) should have cleaned Resident #21's face with the cloth napkin at the table. The staff members (#5 and #6) failed to preserve and promote Resident #21 and 22's dignity while assisting the residents with dining.	F 241		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total number and the actual hours worked, by licensed and unlicensed staff directly responsible for resident care, for	F 356	The process for updating the nurse staffing data at the beginning of every shift has been reviewed. In-service training will be completed by 11/18/10. Nurse staffing data is updated at the beginning of each shift by assigned personnel. (QA) studies will be completed weekly under the direction of the DON (Director of Nursing) until compliance is achieved. After compliance has been achieved, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained.	11-24-10

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F 356	Continued From page 3 each shift on 2 of 3 days of survey (October 19-20, 2010). Findings include: Observation on October 19-20, 2010 identified staffing data (number and actual hours worked by licensed and unlicensed staff directly responsible for resident care) located in a display case on the wall to the left of the 100 Wing nurses station. Facility staff failed to update the board with the staffing data at the beginning of every shift. During interview on 10/20/10 at 12:50 p.m., the administrative nursing staff member (#2) stated, "The UCA [unit coordinator] is responsible" for updating the data every day. She agreed the facility failed to maintain the required posting of staff.	F 356		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store Potentially Hazardous Foods at a safe cold temperature at or below 41 degrees Fahrenheit (F) in 3 of 4 personal refrigerators in	F 371	Resident # 23 personal refrigerator has been replaced with a new one that maintains a temperature of 41^0 or lower. All residents' personal refrigerators have been assessed and if needed replaced to assure they maintain a temperature of 41^0 or less. A policy and procedure for having and maintaining a personal refrigerator is being established. Following completion of the policy and procedure all staff affected by the policy and procedure will be trained. Training will be complete by 11/16/10. (QA) studies will be completed weekly under the direction of the Housekeeping Supervisor. After compliance has been achieved, periodic (QA) studies not less than quarterly will be completed to assure compliance has been maintained.	11-24-10

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F 371	Continued From page 4 the facility.This practice placed residents, who eat food stored in these personal refrigerators, at risk of food borne illness. Findings include: The 2005 Food Code, published by the Food and Drug Administration, stated, page 82, ". . . Potentially Hazardous Food shall be maintained: . . . (2) At a temperature specified in the following: (a) . . . (41 [degrees] F) or less . . ." Observations of Resident #23's personal refrigerator occurred on 10/18/10 at 1:30 p.m. and on 10/19/10 at 9:45 a.m. Two thermometers inside the refrigerator identified an internal temperatures of 58 and 56 degrees F. Observation of the resident's refrigerator on 10/19/10 at approximate one hour intervals showed no change in these temperatures. On 10/19/10 at 2:00 p.m.(more than four hours later), the two thermometers identified an internal temperature of 62 and 60 degrees F. The resident refrigerator contained half of a turkey sandwich. Interview of Resident #23, identified as interviewable by the facility, occurred on the morning of 10/19/10. The resident stated that she had placed the half sandwich in the refrigerator the prior evening and would eat it later. The resident identified other food stored in this refrigerator had "spoiled" approximately two weeks ago. Interviews with housekeeping staff members (#9 and #10) occurred on the afternoon of 10/19/10. The housekeeping staff members identified facility staff had checked and recorded the	F 371		

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F 371	Continued From page 5 temperature of personal refrigerators every Monday since 10/04/10. Review of each housekeeping staff members' records titled, "Daily Record of Refrigerator/Freezer Temperatures," showed the temperature for Resident #23's refrigerator was 50 degrees on 10/04/10 and 56 degrees on 10/18/10. Review of the record identified two other resident refrigerators with temperatures between 48 and 52 degrees F on 10/04/10, 10/11/10, and 10/18/10. When interviewed regarding the required internal temperature for the personal resident refrigerators, the housekeeping staff member (#9) indicated "40 to 53" degrees and the housekeeping staff member (#10) indicated "40 to 50" degrees. Interview with a housekeeping staff member (#9) on 10/19/10 at 2:15 p.m. identified she had visited with an administrative dietary staff member (#11), and she indicated the internal refrigerator temperature should be less than 40 degrees F. On 10/19/10 at 2:30 p.m., an administrative dietary staff member (#11) observed the temperatures and contents of Resident #23's refrigerator and discarded the half of a turkey sandwich.	F 371		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by:	F 454	All oxygen tanks have been secured in a vertical position. The pails containing the mini tanks have been secured to the storage room(s) wall. Re-education on oxygen storage will be completed by 11/18/10. QA (Quality Assurance) studies will be completed weekly under the direction of the Environmental Services Director until compliance is achieved. After compliance has been achieved, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained.	11-19-10

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F 454	Continued From page 6 Based on observation, staff interview, and life safety code, facility staff failed to ensure the facility is maintained to protect the health and safety of residents, personnel and the public, regarding oxygen storage in 1 of 3 oxygen storage areas during 2 of 3 days of survey. Findings include: The Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with National Fire Protection Association (NFPA) 99, 13-5.1, 7-1.2, NFPA 70." The Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 state "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.4.2.7." - Observation on 10/19/10 at 5:30 p.m. and on 10/20/10 at 8:00 a.m., showed an unsecured oxygen tank laying vertically on top of three other oxygen tanks secured horizontally in one of two unsecured 5 gallon pails in an oxygen storage room on the 200 wing. The pail contained one open slot. - During the Environmental Tour at 9:30 a.m. on 010/20/10, observation showed the oxygen tank	F 454		

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F 454	Continued From page 7 positioned as stated above. The maintenance management staff member (#7), present during the Environmental Tour, confirmed the oxygen tank unsecured and placed the tank into the open slot. During interview on 10/20/10 at 11:15 a.m., an administrative nursing staff member (#2) agreed the oxygen tanks should be restrained. She stated, "That shouldn't have happened. We'll have to do training again." The facility failed to protect the health and safety of residents, personnel and the public by leaving oxygen tanks unsecured in storage areas within the facility.	F 454		