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

PRINTED: 11/09/2009
FORM APPROVED
OMB NO. 0938-0391

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 _____	10/22/2009

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 10/19/09 and completed on 10/22/09 the sample included 4 residents for complete review, 12 residents for focused review, and 3 closed records for review. The sample included 3 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 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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, record review, review of facility policy, and staff interview, the facility failed to ensure 2 of 6 sampled residents (Residents #4 and #13), who required a mechanical lift for transfers received the appropriate assistive device to prevent accidents, and 3 of 7 sampled residents (Residents #3, #5, and #16) and 2 supplemental residents (Residents #20 and #21) received appropriate foot rests on their wheelchairs to prevent accidents. Failure to provide adequate assistive devices during transfers placed the residents at risk for falls and injury during the transfers. Findings include: Review of the facility policy titled "Mechanical Lift - Assisted Life - Pal and Princess" occurred on	F 323	Resident #4 is being transferred using a mechanical total body lift. Resident #13 has been evaluated by physical therapy and continues to use the sit to stand mechanical lift. Residents that are currently being transferred with the use of a sit to stand lift have been assessed for appropriateness of the lifting device. The sit to stand mechanical lift policy has been reviewed and revised to include criteria for periodic assessment of the resident's ability to be assisted with the sit to stand mechanical lift. Instruction on using the sit to stand mechanical lift will be given to the direct care staff 11-24-09. An assessment criterion was given to the nurse managers 11-17-09, and will be reviewed with all staff 11-24-09. Quality assurance (QA) studies will be completed monthly to assure that all scheduled and as needed assessments for mechanical lift appropriateness have been accurately completed. After compliance has been met, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained. Use of the mechanical lifts is part of every CNA's skill performance review. QA will be completed by DON or designee per TC DON 12/03/09 KH (quarterly) Resident #3 has foot pedals attached to their wheelchair at all times. Resident #5 has foot pedals attached to their wheelchair at all times. Resident #16 has foot pedals for their wheelchair in their room for use as needed. Resident #20 has foot pedals for their wheelchair in their room for use as needed. Resident #21 refuses to use foot pedals at this time. Assessment criterion is being developed to give weight to all risk factors involved in adding foot pedals to residents' wheelchairs when they possess the ability to propel them self and/or transfer them	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11-20-09

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 323	Continued From page 1 10/22/09. This policy, dated 2002, stated, "Purpose: Assist resident into standing position and maintain standing position while transferring between surfaces. Procedure: . . . 5. Place resident on [sic] feet on designated platform of lift. 6. Slide harness behind the back and around the torso of the resident . . . 8. Attach seatbelt portion of harness around waist . . . 10. Instruct resident to hold onto handlebars while slowly raising them up to standing position . . ." - Review of Resident #13's medical record occurred on October 21-22, 2009. Medical diagnoses included dementia, back pain, and weakness. The quarterly Minimum Data Set (MDS), dated 08/21/09, identified long and short term memory problems, severely impaired in making daily decisions, sometimes makes self understood and understands others and required extensive assistance with all activities of daily living (ADL's). Resident #13's current care plan stated, ". . . Transfer mobility . . . PAL lift [mechanical lift] . . ." Observation on 10/21/09 at 12:40 p.m., showed the certified nursing assistants (CNA's) (#8 and #9) utilized a PAL lift (a mechanical sit to stand lift) and transferred Resident #13 from his wheelchair to the bathroom and then to his bed. Observation showed Resident #13's knees bent to a 45 degree angle, the lift harness up and under his bilateral axilla area, his shoulders shrugged up, the seatbelt loose around his waist, and the handlebars of the lift at his eye level. Observation on 10/21/09 at 4:10 p.m., showed the CNA's (#10 and #11) utilized a PAL lift and transferred Resident #13 from his bed to his wheelchair. Observation showed Resident #13's	F 323	self. After the criteria has been established, residents that do not require foot pedals on their wheelchairs at all times and may routinely or periodically receive assistance propelling their wheelchair will have their plan of care reviewed and revised if necessary.Instruction on the use of foot pedals while transporting residents in wheelchairs will be given to the direct care staff 11-24-09. Quality assurance (QA) studies will be completed monthly to assure that all scheduled and as needed assessments for wheelchair foot pedal usage have been accurately completed. After compliance has been met, periodic (QA) studies not less than semi-annually will be completed to assure compliance has been maintained. QA wee be completed DON or designee per TC DON 12/03/09 KH Res. c MP# 1995 - is now transferred c a total body (maxi) lift & is care planned as such - per TC DON 12/17/09 at 0830 - DL	11-26-09

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F 323	Continued From page 2 knees bent to a 45 degree angle, the lift harness up and under his bilateral axilla area, his shoulders shrugged up, the seatbelt loose around his waist, and the handlebars of the lift at his eye level. - Review of Resident #4's medical record occurred on October 21-22, 2009. Medical diagnoses included diabetes mellitus, ulcers of the left foot and heel, peripheral vascular disease, right hip fracture, and history of cerebral vascular accident. The quarterly MDS, dated 10/09/09, identified short term memory problem, moderately impaired in making daily decisions, sometimes makes self understood and understands others, required extensive assist with all ADL's, and experienced mild pain. Resident #4's current care plan stated, ". . . PAL lift with assist of two." Observations during Resident #4's cares included the following: * 10/20/09 at 8:20 a.m., - showed CNA's (# 2 & #3), utilized a PAL lift and transferred Resident #4 from his bed to the bathroom and then to his wheelchair. Observation showed Resident #4's knees bent to a 45 degree angle and feet not touching the foot support of the PAL lift, the lift harness up and under his bilateral axillary area, his shoulders shrugged up, and the seatbelt loose around his waist. * 10/20/09 at 10:20 a.m., observed CNA's (#4 & #5), utilized a PAL lift and transferred Resident #4 from his wheelchair to the bathroom and then to his chair. Observation showed Resident #4's left leg bent at a 45 degree angle and feet not touching the foot support, the lift harness up under his bilateral axillary area, his shoulders shrugged up, and the seatbelt loose around his waist.	F 323		

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F 323	Continued From page 3 * 10/20/09 at 11:15 a.m., observed CNA's (#2 & #3), utilized a PAL lift and transferred Resident #4 from his chair to the bathroom and to his wheelchair. Observation showed Resident #4's legs bent at a 45 degree angle, the lift harness up under his bilateral axillary area, his shoulders shrugged up, and the seatbelt loose around his waste. During an interview on 10/22/09 at 8:30 a.m., an administrative nurse (#7) stated physical therapy does an initial lift assessment. She stated she does random checks on PAL lift transfers and assisted with Resident #4's transfer a week ago. This staff member stated she expects staff to notify her of any resident changes in transfers. - Observation on 10/20/09 at 3:25 p.m., showed Resident #3 seated in her room in her wheelchair. A CNA (#10) transferred Resident #3 from her room to the dining room in her wheelchair, approximately 50 feet. Observation showed no foot rests on the wheelchair and Resident #3's slippers brushed the floor during the transfer. - Observation on 10/21/09 at 1:55 p.m., showed Resident #5 seated in the hall by nurse's station #3. An administrative staff member (#12) transferred this resident from the hall to the activity room, approximately 100 feet. Observation showed no foot rests on the wheelchair and Resident #5's slippers touched the floor during the transfer. When interviewed on the morning of 10/22/09, an administrative nurse (#1) stated Resident #5's foot pedals are located in her closet and fit her current wheelchair.	F 323		

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F 323	Continued From page 4 During an interview on 10/22/09 at 7:55 a.m., an administrative nurse (#1) stated she expects direct care staff to report any problems they may encounter involving the transfer of a resident to her. She stated staff do an assessment to determine the best mode of transfer for the resident. This staff member stated the residents' wheelchair foot rests are located in the their closets and she expects staff to use the foot rests when transferring a resident. - Observation on 10/19/09 at 12:20 p.m., showed a CNA (#15) transferring Resident #16 in his wheelchair from the dining room to his room, approximately 100 feet. Observation showed no foot rests on the wheelchair and Resident #16's slippers brushed the floor during the transfer. Observaton on 10/21/09 at 11:00 a.m., showed a CNA (#17) transferring Resident #16 in his wheel chair from his room to the dining room. Observation showed no foot rests on the wheelchair and Resident #16's slippers brushed the floor during the transfer in the dining room. Interview of CNAs (#18 and #19) on 10/21/09 at 3:23 p.m., identified Resident #16 had no foot pedals available for use. - Observation on 10/19/09 at 12:15 p.m., showed a CNA (#16) transferring Resident #21 in her wheelchair from the dining room to her room, approximately 100 feet. Observation showed no foot rests on the wheelchair and Resident #21's slippers brushed the floor during the transfer. Observation completed on 10/21/09 at 8:25 a.m. with an administrative nurse (#7) identified Resident #21 had no foot pedals available for use.	F 323		

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F 323	Continued From page 5 - Observation on 10/19/09 at 12:10 p.m, showed an administrative nurse (#7) transferring Resident #20 in his wheelchair from the dining room to his room, approximately 100 feet. Observation showed no foot rests on the wheelchair and Resident #20's slippers touched the floor during the transfer. When interviewed on 10/21/09 at 8:05 a.m., an administrative nurse (#7) identified if facility staff members need to push a resident they should put on foot rests or have the residents propel themselves. This staff member confirmed the brushing of feet on the floor could "easily be an accident waiting to happen."	F 323		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334	The policies for Influenza and Pneumonia vaccine administration have been reviewed and revised. The education will be provided to the resident or the resident's legal representative prior to administration of the vaccine. Residents #1, 2, 3, 4, 6, 10, 11, 13, 15 &, 16 or their legal representatives have been informed of their/the resident's influenza and pneumonia vaccination status and any side effects that may have occurred in relation to the vaccination. All residents or their legal representative will be provided information regarding the benefits and potential side effects of the vaccine before it is administered. Quality assurance (QA) studies will be completed ongoing to assure that all residents or their legal representative have received education on the effects of the vaccine and potential effects. After compliance has been met continuously for ten vaccine administrations it will be completed again at the next facility wide scheduled influenza vaccine administration. QA will be completed by DON or designee per TC DON 12/03/09 KH Informed per TC the DON - re: inconsistency/confusing wording on the Pneumonia Prevention Policy - under the heading "Policy", & under "Procedure" #6. Per TC & DON 12/17/09 at 8:30 a.m. DL DON states will have policy reviewed & make necessary changes. DL	11-26-09

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F 334	Continued From page 6 the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide education to the resident or legal representative regarding the benefits and potential side effects of the influenza immunization before administering the vaccine on a yearly basis for 10 of 16 sampled residents (Resident #1, #2, #3, #4, #6, #10, #11, #13, #15, and #16) who only received education upon admission. Failure to provide education on the risks and benefits associated with the influenza immunization does not give the resident, family, or legal representative the information needed to make an informed consent or denial of the administration of the immunization. Findings include: Review of the facility policy titled "Influenza Prevention" occurred on 10/20/09. This policy, revised 10/01/07, stated "POLICY: Yearly vaccination of all residents to influenza A & B is recommended unless otherwise contraindicated. . . . Vaccines are offered to all eligible October 1st through March 31st. . . . -PROCEDURE: 1. On admission residents and/or their responsible party will be informed of risks of taking or not taking the influenza type A and B vaccine. (Risks include side effects of the vaccine.) 2. The resident or responsible party should sign and date the consent form. The consent form is to be kept in the residents MR [Medical Record] under the consent tab. 3.	F 334		

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F 334	Continued From page 8 Resident consents and physician orders are reviewed yearly. Residents who have refused the vaccine in the past are offered the opportunity to change their vaccine consent status. . . ." The facility included a consent form for the influenza vaccine in the packet the resident, family, or legal representative received on admission. Information listed on the consent form included: all persons recommended to receive the vaccine, possible side effects of receiving the vaccine, and the option to receive or refuse the vaccination. Review of medical records for Resident #1, #2, #3,#4, #6, #10, #11, #13, #15, and #16 occurred on all days of survey. The records indicated the facility administered the influenza vaccine to all residents identified as above in October 2009. The medical records lacked evidence the facility provided education to the resident or the resident's legal representative regarding the benefits and potential side effects of the influenza immunization before administration of the vaccine. The evidence provided on education consisted of the consent form found in the resident's chart completed on admission. The facility provided no further evidence of education prior to administering the annual vaccine each year. During an interview on 10/21/09 at 3:20 p.m., an administrative nursing staff member (#1) stated the facility includes the CDC (Centers for Disease Control) vaccination information statements on the influenza vaccine with the immunization consent form in the packet given and signed on admission. The staff member (#1) confirmed admission is when the resident, resident's family,	F 334		

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F 334	Continued From page 9 or legal representative receives education.	F 334		
F 371 SS=F	483.35(i) SANITARY CONDITIONS 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, manufacturer's recommendations, professional literature review, policy and procedure review, and staff interview, the facility failed to store food in a safe and sanitary manner; and failed to prepare and monitor sanitization solution in 1 of 1 facility kitchen. These practices placed residents, who eat food prepared in the facility, at risk of foodborne illness. Findings include: Review of the facility's policy, "Solution Testing," dated 07/21/95, occurred on the afternoon of 10/21/09. This policy stated, "All solutions used for disinfection/sanitization will be tested for required strength at regular intervals. Required strength will be determined by the manufacturer. . . . 1. Obtain a sample of the solution to be tested. 2. Assure the sample is at room temperature (70-72) [degrees Fahrenheit] if required according to manufacturer's instructions. 3. Test solution according to test strip manufacturer's procedure.	F 371	(1)The solution centers in the Dietary Department have been calibrated to mix the solution at the appropriate concentration according to the manufacturer's specifications. Testing of the three compartment sink and the water solution used for the wiping clothes is being completed every two hours to establish parameters to schedule changing of these solutions. Testing will continue weekly after a schedule has been developed to assure ongoing compliance. All other solution centers in the facility used for the preparation of solutions that sanitize or disinfect have been tested to assure correct solution concentration. Quality assurance (QA) studies will be completed weekly to assure that all solutions used for sanitizing or disinfecting are mixed in the appropriate concentrations. After compliance has been met and sustained for one month, testing will resume at its routinely scheduled testing. QA will be completed monthly to assure that solution centers not meeting the criteria are/were marked "Out of Order" and maintenance is scheduled or completed. QA will be completed by dietitian per TC DON 12/03/09 KH (2)A water collection device has been secured under the condenser to prevent contamination of the area(s) under the condenser. Any food storage areas that have cooling elements without housed drainage have the potential to cause food contamination. These areas have been identified and assessed for the need of a drainage collection device. Quality assurance (QA) studies will be completed weekly to assure that all devices remain in place and are functioning effectively. After compliance has been maintained for one month, periodic (QA) studies not less than quarterly will be completed to assure compliance assured. 11-26-09 QA will be completed by dietitian per TC DON 12/03/09 KH	

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F 371	Continued From page 10 4. If the test fails to meet the approved level redo the test. 5. If the test fails to meet the level again report the problem to the supervisor responsible for the solution center. 6. Identify the solution center as "Out of Order" until the problem has been resolved and the solution consistently tests at the approved level. . . ." Review of the facility's policy, "Food Storage," dated 02/24/97, occurred on the afternoon of 10/21/09. This policy stated, ". . . e. . . . Foods are stored so that there is no contamination from items stored above. . . ." Review of the 2005 Food Code, published by the Food and Drug Administration (FDA), Public Health Reasons, page 376, states ". . . Packages that are not watertight may allow entry of water that has been exposed to unsanitary exterior surfaces of packaging, causing the food to be contaminated . . ." The 2005 Food Code, Public Health Reasons, page 377, states, " . . . Soiled wiping clothes, especially when moist, can become breeding grounds for pathogens that could be transferred to food. Any wiping cloths that are not dry (except those used once and then laundered) must be stored in a sanitizer solution at all times, with the proper sanitizer concentration in the solution. Wiping cloths soiled with organic matter can overcome the effectiveness of, and neutralize, the sanitizer. The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit . . . "	F 371		

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F 371	Continued From page 11 The manufacturer's recommendations, located on a sign posted near a chemical dispenser for "Oasis 146," a quaternary ammonia sanitizer, stated, ". . . testing solution should be between 150-400 ppm [parts per million]" - A tour of the kitchen occurred on 10/21/09 at 8:15 a.m. with two administrative dietary staff members (#13 and #14). Observation showed three buckets, each containing a solution and wiping cloths, located on counters in the kitchen. The dietary staff member (#13) identified these red buckets contained a sanitizer, "Oasis 146," and water solution used to sanitize countertops in the kitchen. When asked to test the concentration of these buckets of sanitizing solution, this staff member obtained a test strip for quaternary sanitizing solutions. The concentration of the solution measured between 0 to 100 ppm for 2 of 3 buckets. The dietary staff member (#14) discarded these buckets of sanitizing solution. The dietary staff member (#14) refilled a bucket with sanitizing solution from an automatic dispenser located near the three compartment sink, and testing of this solution identified the required concentration of 150 ppm. Observation showed three spray bottles, identified by dietary staff member (#13) as containing a sanitizer, "Oasis146," and water solution and available to sanitize equipment, work surfaces, and tables in the dining room. The concentration of the sanitizing solution obtained using test strips, measured between 0 and 100 ppm in 3 of 3 spray bottles. The dietary staff member (#13) refilled a spray bottle using an automatic dispenser located in the utility closet. The concentration of this solution measured 0 ppm.	F 371		

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 _____	10/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 When interviewed, during the dietary tour, the dietary staff member (#14) stated she thought this automatic dispenser located in the utility closet did not work properly so she had been using the automatic dispenser located near the three compartment sink to obtain sanitizing solution. Facility staff failed to post an "Out of Order" sign, per facility policy, on the automatic dispenser, located in the utility closet and suspected of malfunctioning. Review of the monitoring log, titled "Test Strip Sanitizer Solution," on the afternoon of 10/21/09, identified weekly testing of the spray bottles and three compartment sink only. Facility staff recorded the test results July - October 2009 as "ok." On October 16, 2009, a facility staff member recorded in the column for spray bottles the statement, "refilled a couple of bottles." - Observation in a walk-in freezer, during the kitchen tour on 10/21/09 at 8:25 a.m., identified ice build up, formed into icicles on a wire shelf beneath the air compressor. Observation showed two cases of raw pork loins, stored on a shelf beneath this ice build up. Additionally, ice build up formed into sheets of ice on the two cases. Observation of the interior surface of one of these cases showed a wet area that had refrozen above the plastic covered pork loins. Another shelf, directly below the air compressor, contained trays of individual bowls of cabbage rolls covered with plastic lids. The lid on one of these bowls showed a crack. The administrative dietary staff member (#13) discarded the bowl. Observation showed small ice deposits formed in a scattered layer on an open case containing two bags of precooked salisbury steaks. Facility staff had closed one of	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 13 these bags with a twist tie. The administrative staff member (#14) discarded this bag of steaks. When interviewed on the morning of 10/21/09, an administrative dietary staff member (#13) agreed dietary staff should protect frozen food products from potential contamination from unsanitary water sources and use/maintain sanitizing solutions at a concentration recommended by the manufacturer.	F 371		