STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING _____ B. WING _____	05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started 05/17/21 and concluded on 05/19/21.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, the facility failed to implement policies related to the investigation and reporting of abuse/neglect for 1 of 1 sampled resident (Resident #17) with an injury of unknown origin. Failure to recognize an injury of unknown origin as potential abuse/neglect and implement their investigation/reporting policy placed all residents at risk for abuse/neglect and possible injury. Findings include: Review of the facility policy "Abuse and Neglect (including Elder Justice Act)" occurred on 05/19/21. This policy, dated 08/25/20, stated, ". . . Identification: 1. Any staff witnessing or	F 607	F607 □ For resident #17 and all other residents at Luther Memorial Home, unexplained bruises will be investigated per newly developed facility policy, Procedure for Injuries. This policy requires staff to report all abrasions, bruises, skin tears (any injury) to the unit charge nurse as soon as possible after injury is discovered. The unit charge nurse shall address the injury and start appropriate treatment. If the injury has previously been reported and investigated there is no need to address this again. If injury is new and this is the first report of injury, it must be documented, including description and measurements, in a progress note and an	6/23/21

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

Electronically Signed | 06/03/2021

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F 607	Continued From page 1 possessing knowledge of any act (or suspected act) involving . . . injuries of unknown origin such as bruising . . . must IMMEDIATELY notify the charge nurse, who will IMMEDIATELY notify the D.O.N. [Director of Nursing] and ADMINISTRATOR and SOCIAL SERVICES. . . . 2. Injuries of unknown source mean source of injury was not observed by any person OR the source of injury could not be explained by the resident AND the injury is suspicious because of the extent of the injury or the location of the injury . . ." Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . Cognitive function: . . . BIMS [Brief Interview for Mental Status] TESTING: 2/19/21 score 7, indicating severe cognition impairment. Cognition is noted to vary. . . Memory loss: Mental function does vary. . . aphasia, right hemi-plegia - Medication: ASA [Aspirin] - Potential for bruising and bleeding. . . Approach: Monitor skin for s/s [signs and symptoms] of bruising d/t [due to] ASA use. Be gentle with cares and transfers. Observation on 05/17/21 at 3:13 p.m., showed Resident #17 with two bruises on her right forearm. One bruised measured approximately the size of a quarter and the other one a little smaller. When questioned about the bruises Resident #17 stated some girl "squeezed" her arm too hard. Observation on 05/18/21 at 5:00 p.m., showed the same two bruises and when questioned Resident #17 stated someone grabbed her arm too tightly.	F 607	event started per the charge nurse. If bruise is unexplained, and meets criteria for investigation, it will be reported to DON, Unit Manager or Social Services. Investigation will be conducted by DON, Nurse Manager or Social Services as a means of identifying potential abuse. Charge nurse is to add injury and any treatment to the care plan and treatment administration record. The charge nurse is to notify the resident□s representative of the injury. If injury is severe or there is any suspected abuse the charge nurse will notify physician, DON, LBSW, and Administrator. If the injury was witnessed or staff can explain how injury occurred and are nearly certain, this is to be documented in the event report and in the progress notes. DON or Nurse Managers will review all events and determine if criteria is met for unknown injury investigation. Criteria includes any unexplained bruise or skin tear larger than 2 cm and unexplained bruises or skin tears occurring 3 or more times per week. Investigation will be documented in the event by nursing management, reviewed by Administrator and signed if in agreement with findings of investigation. If abuse is suspected, the incident will be reported to the ND State Department of Health and Law Enforcement if indicated by, suspicion of intentional abuse that results in serious bodily injury. On 5/19/21, Unit Manager assessed resident #17□s right forearm. Bruises noted were documented in progress note and in event. Investigation for cause of	

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F 607	Continued From page 2 During an interview on 05/19/21 at 11:00 a.m., a licensed nurse (#4) stated she would look at Resident #17's arm. A few minutes later the nurse (#4) reported the resident does have bruises, she will start an event form and notify the Unit Manager. Resident #17's medical record failed to identify the resident's bruises. During an interview on 05/19/21 at 1:10 p.m., a supervisory nurse (#6) stated she assessed Resident #17's bruises and documented the assessment. During an interview on 05/19/21 at 1:35 p.m. the nurse (#4) reported Resident #17 had a bath on Monday and she expected the bath aide to report any bruises. During an interview on 05/19/21 at 1:45 p.m., the bath CNA [Certified Nursing Assistant] (#3) stated she did give Resident #17 a bath on Monday (05/17/21) and she had the bruises. The CNA reported Resident #17 had the bruises last week on her bath. She thought the bruises were old and did not report the bruises. Resident #17's progress notes identified the following: 05/19/21 1:05 p.m. "BRUISES: Charge nurse reported that resident has bruises noted to RFA [right forearm]. Writer assessed and mid [middle]-RFA two bruises measuring about 2.5 x 2 cm [centimeters] and 1.5 x 2 cm. One bruise near right elbow measures about 1 x 1 cm. All bruises purple in color. Writer asked resident if	F 607	bruises was completed by LBSW and Unit Manager. No abuse was determined. Bruises are monitored weekly by charge nurses until resolved. All new bruises will be reported by C.N.A.s, LPNs, RNs to the unit charge nurse as soon as possible after discovery. Weekly skin assessments will be conducted for each resident at Luther Memorial Home by unit charge nurse or unit manager for 2 months, then twice per month for 2 months, then monthly for 2 months to assure bruises are being reported per policy and 100% compliance is achieved. C.N.A. and Nursing staff will be educated regarding reporting injuries as soon as possible after discovery and the process for documenting, notifying, and investigating injuries of unknown origin at meetings being held June 8, 9, and 15, 2021. QA data monitoring will be conducted monthly by QA nurse and DON to assure any bruises of unknown origin that meet criteria for investigation are investigated for cause and potential abuse for a minimum of 6 months and until compliance is determined. QA data will be reported to the QAPI committee monthly.	

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F 607	Continued From page 3 she knows how bruises occurred. Res [resident] reported that a "girl" grabbed her arm "a long time ago." Resident unable to tell writer who or which staff member and was not clear as to what shift. Resident stated that she has not seen this "girl" in a long time and that she use [sic] to know her name but no longer does. Resident did not report this incident at the time of occurrence but stated that she felt the girl was 'too rough.' Writer spoke with daughter [name] and she stated that she has had no concerns with staff or anyone else being too rough with resident. She stated she noticed the bruises about 1-2 weeks ago and that she asked [resident name] about them and [resident name] stated the girl was 'just a little too tight.'. . ." The facility staff failed to report and investigate Resident #17's suspicious bruises on the resident's right forearm.	F 607		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide assistance and supervision necessary to prevent accidents for 3 of 9 sampled residents (Resident #14, #31, and #70) identified with falls. Failure to provide	F 689	F689- For residents #14, #31, #70 and all other residents at Luther Memorial Home, staff will provide adequate assistance and supervision with transfers according to	6/23/21

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F 689	Continued From page 4 supervision and adequate assistance with transfers/ambulation may result in falls and injuries. Findings include: - Review of Resident #14's medical record occurred on all days of survey. Diagnoses included dementia, a history of a right femur fracture, and a history of falls. The current care plan stated, ". . . Problem . . . IMPAIRED MOBILITY/AMBULATION R/T [related to]: Fractured Right hip/femur . . . Alzheimer's . . . Approach . . . Transfers: Extensive assist of 2 . . . gait belt- yes . . . Walking in Corridor: Ext [extensive] assist of 2. Gait belt: Yes . . . Walking in Room: Extensive assist of 2. Gait belt: Yes . . ." A nurse's note, dated 05/06/21 at 5:51 p.m., stated, ". . . Called to MLL [memory care unit] at 540p [p.m.], when resident was lowered to the floor. CNA [certified nursing assistant] reports she was assisting him and he became resistive and pushed on her, then knees gave out and she lowered him to the floor onto his buttocks. On assessment no injury noted and no complaint of pain. . . ." Observation on 05/18/21 at 3:33 p.m. showed a CNA (#1) placed a gait belt around Resident #14's waist, assisted him to stand and ambulated with one assist to the resident's room to use the bathroom. The CNA then ambulated with Resident #14 to the dining area for activities. Upon completion of the activity, the CNA ambulated with Resident #14 down the hallway and back to the TV area.	F 689	the resident□s plan of care to prevent injuries and accidents. Residents #14, #31, and #70 will each have a toileting transfer observed by the charge nurse daily, each shift for 7 days, then 12 residents (3 residents per wing) will have one transfer observed by the charge nurse each shift, per the week, for 3 months, then 8 residents (2 residents per wing) will have one transfer observed by the charge nurse each shift, per the week then 4 residents (1 resident per wing) will have one transfer observed by the charge nurse each shift per the week to ensure that the plan of care for safe transfers is followed and correct transfer method is used, correct number of staff assist with the transfer and proper amount of supervision is provided. Nursing and C.N.A. staff will be educated regarding using correct transfer methods and providing supervision of residents according to their plan of care at staff meetings being held June 8, 9 and 15, 2021. Following staff education, observations of transfers and supervision QA data will be collected by charge nurses observing transfers of residents each week on all shifts. This data will be turned into the QA nurse manager. QA data will be reported to the QAPI committee monthly. QA data collection and monitoring will continue for a minimum of 6 months and compliance is determined.	

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F 689	Continued From page 5	F 689		

- Review of Resident #31's medical record occurred on all days of survey. Diagnoses included dementia and a history of falls. The current care plan stated, ". . . Problem . . . IMPAIRED MOBILITY/AMBULATION R/T WEAKNESS, DEMENTIA . . . Approach . . . Transfers: Extensive assist of 1 and standing lift . . . Problem: Resident at risk for falling R/T limited mobility, attempts to self transfer without staff support, weakness. Approach . . . Do not leave resident alone in bathroom . . ."

A nurse's note, dated 03/25/21 at 6:30 p.m., stated, ". . . Fall: Staff alerted this nurse that resident had fallen from his wheelchair in the bathroom. Resident was found sitting between his wheelchair and the toilet with L) [left] foot pedal to his back and R) [right] foot pedal under B) [bilateral] knees. He denies pain. ROM WNL [range of motion] [within normal limits]. Resident hoyered [full body mechanical lift] from floor with assist x3. No noted redness/bruising or injuries noted. Resident reports hitting his head on the wall when leaning back. Neuro assessment completed and WNL. Careplan updated that resident cannot be in bathroom alone. . . ."

Observation on 05/18/21 at 9:04 a.m. showed a CNA (#3) transferred Resident #31 from his wheelchair to the toilet using a standing lift. The CNA then gave the resident the call light and left the room. At approximately 9:15 a.m., Resident #31 used the call light, and the CNA returned to his room to finish cares.

During an interview on 05/19/21 at 4:13 p.m., a supervisory nurse (#2) confirmed two staff should ambulate with Resident #14, and staff should not

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F 689	Continued From page 6	F 689		

leave Resident #31 alone in the bathroom.

- Review of Resident #70's medical record occurred on all days of survey. Diagnoses included Alzheimer's Disease. The resident's care plan date 03/14/21 stated, ". . . Impaired mobility/ambulation R/T dementia. . . . Approach Transfer: Extensive assist of 2, may use Standing Lift with butt trap 2 assists after nurse assessment if unable to stand. . . ."

An event report dated 03/14/21 stated, ". . . Called to room by CNA at 440pm [4:40 p.m.] with report that resident was lowered to floor when knees became weak. On assessment sitting bathroom floor [sic] on buttocks with legs extended. Staff report she was lowered to her knees and then positioned to sitting position. Denies pain and no injury noted. Assisted to standing by 4 staff and seated on toilet. Continues to deny pain. . . ." The event report identified one CNA caring for the resident at the time of the fall.

An event report dated 03/24/21 stated, "Called to room for fall. CNA present, states was transferring resident and knees gave out, CNA lowered to floor [sic]. Resident sitting on the floor with back against recliner, gait belt on, shoes on. Denies pain other than to her knees. ROM [range of motion] as prior to fall. Assisted to standing with 3 staff and gait belt, assisted to wheelchair. Vitals WNL. Continues to deny pain other than to knees . . ." The event report identified one CNA caring for the resident at the time of the fall.

During an interview on the afternoon of 05/19/21, a supervisory nurse (#6) confirmed at the time of

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F 689	Continued From page 7 the above falls Resident #70 required assistance of two staff members for transfers and the event report identified one staff member assisting the resident at the time of each fall.	F 689		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency equipment remained in safe operating condition for 1 of 2 suction machines (in the supply room). Failure to ensure the suction machine remained functional in the event of an emergency could delay the availability of suction use for residents and placed residents at risk for choking and aspiration. Findings include: Observation of the suction machine stored in the supply room occurred on the morning of 05/19/21 with a licensed nurse (#4). Observation showed the licensed nurse (#4) attempted multiple times to connect the tubing to the suction machine and the collection canister and the connections did not fit. After approximately five minutes the licensed nurse went to the office of an administrative nurse (#5) and requested assistance. The administrative nurse removed a filter device connected to the machine and stated, "I have no idea where this came from." The administrative nurse (#5) connected the tubing to the canister and the machine which	F 908	F908- Luther Memorial Home will maintain resident suction equipment in ready to use, safe operating condition for all residents. All suction machines within Luther Memorial Home have been checked and set up with correct filters, tubing and connectors as needed. Nursing staff will be educated on suction machine set up and use at nursing staff meeting on June 9, 2021. Demonstrations of set up and use will be completed by each nurse at the meeting to ensure competency with set up and use of suction machines. All suction machines within Luther Memorial Home will be checked weekly by QA nurse or designee for proper set up and function. This monitoring will be conducted weekly for a minimum of 6 months. The weekly monitoring data will be reported monthly the QAPI committee to ensure compliance is achieved and maintained.	6/23/21

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F 908	Continued From page 8 then produced suction. During an interview on 05/19/20 at 5:20 p.m., an administrative nurse (#5) stated she still does not know where the filter device came from. The nurse confirmed the filter device caused the connections not to fit and the suction machine would not work.	F 908		