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 _____	06/14/2012

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

(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 June 11, 2012 and completed on June 14, 2012 the sample included four (4) residents for complete review, twelve (12) residents for focused review, and three (3) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	1. Corrective action will be accomplished by having the MDS assessments accurately completed. 2. All residents with an ostomy or surgical wound have the potential to be affected by this. 3. The facility put the following measures in place: A) Mandatory MDS team meeting on 6-21-12 (see attachments #1 & 2). 4. Corrective action will be accomplished by July 12, 2012. 5. Our facility plans on monitoring as follows: A) QA coordinator or designated staff person will do a QA audit on admit any resident that has an ostomy or surgical wound for three months (see attachment #3).	7-12-12

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

7/11/12

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manuals (Version 3.0), dated October 2011 and April 2012, and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 1 of 1 sampled resident (Resident #10) with an ileostomy and an abdominal wound. Failure to accurately assess and code the MDS may affect the level of care provided by staff to the residents. Findings include: The Long-Term Care Facility RAI User's Manual stated: * Page H-2 H0100: Appliances ". . . Coding Instructions - check next to each appliance that was used at any time in the past 7 days. . . H0100C, ostomy (including urostomy, ileostomy, and colostomy) . . ." * Page H-10-11 H0400: Bowel Continence ". . . Coding Instructions - . . . Code 9, not rated: if during the 7-day look-back period the resident had an ostomy . . . " * Page M-30 M1040: Other Ulcers, Wounds and Skin Problems "Definitions . . . Surgical Wounds - Any healing and non-healing open or closed surgical incisions . . . or drainage sites. . . ." * Page M-35 M1200 F Surgical Wound Care ". . . Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing .	F 278		

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F 278	Continued From page 2 . .application of dressings of any type . . ." Review of Resident #10's medical record occurred on June 12-14, 2012. The facility admitted the resident in March 2012 with diagnoses including ileostomy and non-healing abdominal wound. A skin assessment conducted 03/06/12 identified "chronic open wounds from surgical procedure in 2009." The admission MDS, dated 03/19/12, and the quarterly MDS, dated 06/06/12, identified the following: * Section H0100C failed to identify the ostomy * Section H0400 identified bowel continence as '0' or continent of bowel on all occasions of bowel movements * Section M1040E failed to identify 'surgical wound' * Section M1200F failed to identify 'surgical wound care' Resident #10's current care plan stated, ". . . Problem: Impaired Skin Integrity: Ileostomy, non-healing wound to abdomen - requiring dressings and monitoring daily. Approach - 03/07/12 change ostomy device q [every] week and prn [as needed] as res [resident] allows. 03/06/12 tx [treatment] daily to abdomen - NS [normal saline] and cover with primapore daily. . . ." Resident Progress Notes for Resident #10 identified the following: 03/07/12, 9:17 a.m. ". . . presence of ostomy in right lower abdominal quadrant noted. . . ."	F 278		

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F 278	Continued From page 3 03/09/12, 9:00 a.m. ". . . Midline abdominal incision is present and has two open areas noted at this time. . . ." Observation of a nurse (#1), on 06/12/12 at 1:45 p.m., showed she performed Resident #10's abdominal wound care, dressing change, and the presence of an ostomy. During an interview on 06/13/12 at 9:40 a.m., a staff nurse (#1) stated Resident #10's abdominal wound was open on admission to the facility. During an interview on the afternoon of 06/13/12, an administrative nursing staff member (#3) stated the MDS sections related to the ostomy were incorrectly coded and had not considered the wound a surgical wound.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, and staff interview, the facility failed to properly administer medication to 1 of 1 supplemental resident (Resident #20) who received insulin via an "insulin Pen" (a small pen shaped device prefilled with insulin.) Failure of facility staff to follow the manufacturer's recommendation of properly "priming" (a procedure to expel the air from the needle attached to the insulin Pen) prior to giving Resident #20 his insulin injections has the	F 281	1. Corrective action will be accomplished by having licensed nursing staff prime insulin pens according to manufacturer's recommendations. 2. All residents receiving insulin via an insulin pen have the potential to be affected by this. 3. The facility put the following measure into place: A) Mandatory licensed nurse meeting on 6-19-12 (see attachments #4 & 5). 4. Corrective action will be accomplished by July 12, 2012.	

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F 281	Continued From page 4 potential for this resident to receive the incorrect dose of insulin. Findings include: Review of the "Prefilled Insulin Delivery Device User Manual," provided by the facility, occurred on 06/13/12. These instructions, dated April 17, 2009, stated, * "Read and follow all of these instructions carefully. If you do not follow these instructions completely, you may get too much or too little insulin. . . . * Prime every time. The Pen must be primed to a stream of insulin (not just a few drops) before each injection to make sure the Pen is ready to dose. * You may need to prime a new Pen up to six times before a stream of insulin appears. . . . * Turn the dose knob clockwise until the number '2' is seen in the dose window. . . . * Hold your Pen with the needle pointing straight up. . . . You should see a stream of insulin come out of the tip of the needle. . . ." Observation of a nurse (#1) during medication pass, on 06/12/12 at 11:00 a.m., showed the nurse primed the insulin Pen with 2 units while holding the Pen upright with the cap on the needle. The nurse confirmed she utilized a new Pen for this administration of sliding scale insulin. Failure to remove the cap from the needle of the Pen did not permit the nurse (#1) visualization of the needle to ensure a stream of insulin appeared. During an interview on 06/13/12 at 9:30 a.m., an	F 281	5. Our facility did an audit on the nurse that incorrectly primed the pen (see attachment #6) and the remaining licensed nurses reviewed the proper guidelines at the 6-19-12 nurses meeting (see attachment #4 & 5).	7-12-12

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F 281	Continued From page 5 administrative nurse (#2) confirmed staff failed to follow the priming directions.	F 281		