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 _____	07/07/2011

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 survey started on 07/05/11 and completed on 07/07/11, the sample included four (4) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review.	F 000		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272	1. Corrective action will be accomplished by having all Z0500Bs scheduled at least 1 day after the ARD to account for the information for the last day of the assessment period up until 12 MN. 2. All residents having a MDS completed have the potential to be affected by this. 3. The facility will put the following measures in place: A) Mandatory MDS team meeting on 7-27-11 (see attachments #1a & 1b). 4. Corrective action will be accomplished by August 11, 2011. 5. Our facility plans on monitoring as follows: A) QA coordinator or designated staff person will do a QA audit on any resident that has a MDS scheduled in the month of August, 2011 (see attachment #1c).	8/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Adm | (X6) DATE: 7/28/11

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.

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

PRINTED: 07/19/201
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 survey started on 07/05/11 and completed on 07/07/11, the sample included four (4) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review.	F 000		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272	1. Corrective action will be accomplished by having all Z0500Bs scheduled at least 1 day after the ARD to account for the information for the last day of the assessment period up until 12 MN. 2. All residents having a MDS completed have the potential to be affected by this. 3. The facility will put the following measures in place: A) Mandatory MDS team meeting on 7-27-11 (see attachments #1a & 1b). 4. Corrective action will be accomplished by August 11, 2011. 5. Our facility plans on monitoring as follows: A) QA coordinator or designated staff person will do a QA audit on any resident that has a MDS scheduled in the month of August, 2011 (see attachment #1c).	8/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admn | (X6) DATE: 7/28/11

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.

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 272	Continued From page 1 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility failed to use the entire required days of observation when completing the Minimum Data Sets (MDSs) on 16 of 16 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident's performance and health status. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page A-23 and Z-8 state, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations	F 272		

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 272	Continued From page 2 and events through the end of the day (midnight) of the ARD . . . For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as completed by the RN assessment coordinator . . ." - Record review for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16 occurred between July 5th and July 7th of 2011. Review of these records revealed the facility staff failed to collect MDS assessment information for the last day of the assessment period up until 12 midnight, as the RN (registered nurse) Assessment Coordinators signed and dated each assessment as completed on the last observation day (the ARD). This resulted in facility staff failing to collect assessment information for all of the last day of the observation period, as required. For Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16, review of the ARD and the date of completion (Z0500B) on the current OBRA (Omnibus Budget Reconciliation Act) MDSs identified the following: * Resident #1 - quarterly assessment - ARD and Z0500B date of 06/24/11 * Resident #2 - annual assessment - ARD and Z0500B date of 05/23/11 * Resident #3 - quarterly assessment - ARD and Z0500B date of 05/18/11 * Resident #4 - quarterly assessment - ARD and Z0500B date of 06/21/11 * Resident #5 - annual assessment - ARD and Z0500B date of 05/26/11 * Resident #6 - annual assessment - ARD and Z0500B date of 05/30/11 * Resident #7 - quarterly assessment - ARD	F 272		

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 272	Continued From page 3 and Z0500B date of 06/22/11 * Resident #8 - quarterly assessment - ARD and Z0500B date of 06/10/11 * Resident #9 - quarterly assessment - ARD and Z0500B date of 06/07/11 * Resident #10 - quarterly assessment - ARD and Z0500B date of 04/15/11 * Resident #11 - quarterly assessment - ARD and Z0500B date of 06/07/11 * Resident #12 - quarterly assessment - ARD and Z0500B date of 06/22/11 * Resident #13 - annual assessment - ARD and Z0500B date of 06/13/11 * Resident #14 - quarterly assessment - ARD and Z0500B date of 06/13/11 * Resident #15 - annual assessment - ARD and Z0500B date of 06/25/11 * Resident #16 - annual assessment - ARD and Z0500B date of 06/15/11 On 07/06/11 at 11:05 a.m., two administrative nursing staff members (#3 and #4) verified the facility staff failed to collect MDS assessment information for the last day of the assessment period up until 12 midnight, as the RN (registered nurse) Assessment Coordinators signed and dated the above assessments as completed on the last observation day (the ARD) prior to midnight.	F 272		
F 278 SS=C	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.	F 278	1. Corrective action will be accomplished by not coding side rails as a restraint on the MDS assessment if restraint assessment reveals it is not a restraint and all MDS staff will sign Z0400 as to what sections were exactly completed.	8/11/11

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

PRINTED: 07/19/201
FORM APPROVED
OMB NO. 0938-039

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 _____	07/07/2011

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 278	Continued From page 4 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 material and false statement. This REQUIREMENT is not met as evidenced by: 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility staff failed to accurately complete the restraint section of the Minimum Data Set (MDS) for 13 of 13 sampled residents (Resident #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, and #15) identified on their MDSs as using bed rails. Failure to accurately complete portions of the MDS on these residents does not allow each resident's comprehensive assessment to reflect care provided, consistent with their individual needs and problems.	F 278	2. All residents having a MDS have the potential to be affected by this. 3. The facility put the following measures into place: A) Mandatory MDS team meeting 7-26-11 (see attachments #1a & 1b). 4. Corrective action will be accomplished by August 11, 2011. 5. Our facility plans on monitoring as follows: A) QA coordinator or designated staff person will do a QA audit on all the MDS assessments done in our facility in August, 2011 (see attachment #1c).	

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	760 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 278	Continued From page 5 Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting * research and policy development . . ." Each person completing a section of the MDS is required to sign the Attestation Statement (Z0400) on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care . . ." - Record review for Resident #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, and #15 occurred between July 5th and July 7th of 2011. Review of these resident's records revealed the facility staff failed to accurately code the restraint section on their MDSs. The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page P-1 defines a	F 278		

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

PRINTED: 07/19/201
FORM APPROVED
OMB NO. 0938-039

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 _____	07/07/2011

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 278	Continued From page 6 restraint as, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Bed rails used by these residents for repositioning and turning in bed were coded on the MDS as a physical restraint, even though they failed to meet the definition of a physical restraint. During an interview on 07/08/11 at 12:10 p.m., an administrative nurse (#3) identified bed rails used in their facility, for the above-stated residents, do not restrain. Rather these bed rails are used by the residents for repositioning and turning in bed. For Resident #2, #3, #4, #5, #6, #7, #8, #10, #11, #12, #13, #14, and #15, review of Section P: Restraints on the current OBRA (Omnibus Budget Reconciliation Act) MDSs identified the following: * Resident #2 - annual assessment - ARD of 05/23/11 - bed rail used daily * Resident #3 - quarterly assessment - ARD of 05/18/11 - bed rail used daily * Resident #4 - quarterly assessment - ARD of 06/21/11 - bed rail used daily * Resident #5 - annual assessment - ARD of 05/28/11 - bed rail used daily * Resident #6 - annual assessment - ARD of 05/30/11 - bed rail used daily * Resident #7 - quarterly assessment - ARD of 06/22/11 - bed rail used daily * Resident #8 - quarterly assessment - ARD of 06/10/11 - bed rail used daily * Resident #10 - quarterly assessment - ARD of 04/15/11 - bed rail used daily	F 278		

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

PRINTED: 07/19/201
FORM APPROVED
OMB NO. 0938-039

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 _____	07/07/2011

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 278	Continued From page 7 * Resident #11 - quarterly assessment - ARD of 06/07/11 - bed rail used daily * Resident #12 - quarterly assessment - ARD of 06/22/11 - bed rail used daily * Resident #13 - annual assessment - ARD of 06/13/11 - bed rail used daily * Resident #14 - quarterly assessment - ARD of 06/13/11 - bed rail used daily * Resident #15 - annual assessment - ARD of 05/25/11 - bed rail used daily 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility staff failed to ensure that each individual staff member who completed a portion of the MDS assessment signed and certified the accuracy of that portion of the assessment, or accurately identified the section(s) or portion(s) they completed for 16 of 16 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized." Page Z-7 states, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . . Two or more staff members can complete items within the same section of the MDS. When filling in the information for	F 278		

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

PRINTED: 07/19/201
FORM APPROVE
OMB NO. 0938-039

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 _____	07/07/2011

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 278	Continued From page 8 Z0400 (the (attestation statement of accuracy), any staff member who has completed a subset of item within a section should identify which item(s) he/she completed within that section . . ." - Record review for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16 occurred between July 5th and July 7th of 2011. Review of these records revealed the facility staff failed to ensure that each individual staff member who completed a portion of the MDS assessment signed and certified the accuracy of that portion of the assessment, or accurately identified the section(s) or portion(s) they completed. For Resident #1, #2, #4, #5, #6, #10, #13, #14, and #16, review of item Z0400 (the attestation statement) on their current MDSs showed additional staff members failed to sign and accurately identify the specific section(s) or portion(s) they completed as evidenced by: * Resident #1's quarterly MDS, dated 06/24/11, identified a licensed social worker (LSW) completed sections A-E and Q, and a licensed registered dietitian (LRD) completed sections G and K. * Resident #2's annual MDS, dated 05/23/11, identified a LSW completed sections A-E and Q, a LRD completed sections G and K, and an activity director (AD) completed section F. * Resident #4's quarterly MDS, dated 06/21/11, identified a LSW completed sections A-E and Q, and a LRD completed sections G and K.	F 278		

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

PRINTED: 07/19/201
FORM APPROVE
OMB NO. 0938-039

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 _____	07/07/2011

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 278	Continued From page 9 * Resident #5's annual MDS, dated 05/28/11, identified a LSW completed sections A-E and Q, a LRD completed sections G and K, and an AD completed section F. * Resident #6's annual MDS, dated 05/30/11, identified a LSW completed sections A-E and Q, a LRD completed sections G and K, and an AD completed section F. * Resident #10's quarterly MDS, dated 04/15/11, identified a LSW completed sections A-E and Q, and a LRD completed sections G and K. * Resident #13's annual MDS, dated 06/13/11, identified a LSW completed sections A-E and Q, and a LRD completed sections G and K. * Resident #14's quarterly MDS, dated 06/13/11, identified a LSW completed sections A-E and Q, and a LRD completed sections G and K. * Resident #16's annual MDS, dated 06/15/11, identified a LSW completed sections A-E and Q, a LRD completed sections G and K, and an AD completed section F. For Resident #3, #7, #8, #9, #11, #12, and #15, review of item Z0400 (the attestation statement) on their current MDSs showed individual staff members failed to accurately identify the specific section(s) or portion(s) they completed, as these attestation statement showed two staff members completed some of the exact same sections (i.e. A, B, C, D, E, G, K, and Q) as evidenced by: * Resident #3's quarterly MDS, dated 05/18/11, identified a registered nurse (RN) completed	F 278		

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

PRINTED: 07/19/201
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 278	Continued From page 10 sections A-S, a LSW completed sections A-E and Q, and a LRD completed sections G and K. * Resident #7's quarterly MDS, dated 06/22/11, identified a RN completed sections A-S, a LSW completed sections B-E and Q, and a LRD completed sections G and K. * Resident #8's quarterly MDS, dated 06/10/11, identified a RN completed sections A-Z, a LSW completed sections B-E and Q, and a LRD completed sections G and K. * Resident #9's quarterly MDS, dated 06/07/11, identified a RN completed sections A-S, a LSW completed sections B-E and Q, and a LRD completed sections G and K. * Resident #11's quarterly MDS, dated 06/07/11, identified a RN completed sections A-S, a LSW completed sections B-E and Q, and a LRD completed sections G and K. * Resident #12's quarterly MDS, dated 06/22/11, identified an RN completed sections A-S, a LSW completed sections B-E and Q, and a LRD completed sections G and K. * Resident #15's annual MDS, dated 05/25/11, identified a RN completed sections A-S, a LSW completed sections B-E and Q, an AD completed section F, and a LRD completed sections G and K. On 07/06/11 at 11:05 a.m., two administrative nursing staff members (#3 and #4) verified the facility staff failed to accurately complete item Z0400 of the MDS. When questioned if the LRD	F 278		

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 278	Continued From page 11 actually completes all of section G (Activities of Daily Living), these staff members identified she only completes item G0110H. (Eating) in section G.	F 278		
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, review of professional references, and staff interview, the facility failed to ensure 1 of 8 sampled residents (Resident #1) identified by the facility with swallowing problems received the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being regarding positioning during 2 of 4 meals and snacks observed. Failure to position Resident #1 in an upright position placed him at risk of aspiration of food and drink items and development of undesired side effects. Findings include: Swigert, N. B. "The Source for Dysphagia," Third Edition, LinguiSystems, Inc., East Moline, Illinois, 2007, page 125, states "Chapter 7, Planning Dysphagia Treatment, Compensatory Treatment Techniques . . . 1. Appropriate Seating, During	F 309	1. Corrective action will be accomplished by placing resident in a dining room chair or securing wheelchair in upright position each time the resident eats. 2. Only this resident has the potential to be affected by this. 3. The facility put the following measures into place: A) Will hold a mandatory Meadowlark Lane meeting August 4th, 2011 (see attachment #2a). B) Memo put out 7-7-11 to staff members caring for this resident (see attachment #2b). C) One more standing lift was purchased for Meadowlark Lane (see attachment #2c). 4. Corrective action will be accomplished by August 11, 2011. 5. Our facility plans on monitoring as follows: A) QA coordinator or designated staff person will do a QA audit 5x/week for 2 weeks, 3x/week for 2 weeks, and 1 per week for 1 month (see attachment #2d).	8-11-11

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

PRINTED: 07/19/201
FORM APPROVE
OMB NO. 0938-039

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 _____	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	760 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 309	Continued From page 12 the oral intake of medicines, foods, and/or liquids, it is optimal for a patient to be seated at a 90 [degree] angle . . . The 90 [degree] position allows the patient to control material in the oral cavity with a minimal impact of gravity. This position must be maintained during and following the meal. . . ." Dugan, D., "Successful Nursing Assistant Care," Second Edition, Hartman Publishing, Albuquerque, 2008, pages 259-260, states "Chapter 14, . . . 13. . . . guidelines for preventing aspiration . . . swallowing problems cause a high risk for choking on food or drink. When a person chokes, mucus, food or fluids . . . may move into the lungs. Inhaling food or drink into the lungs is called aspiration, which can cause pneumonia . . . Preventing Aspiration, Place residents in proper position for eating and drinking. They must sit upright at a 90-degree angle. . . . Do not feed residents in a reclining position. . . ." The roster of residents provided by the facility after the initial entrance conference, on 07/05/11 at 11:30 a.m., identified Resident #1 had swallowing issues. Review of Resident #1's medical record occurred on July 05-07, 2011. The facility admitted the resident in January 2009. Current diagnoses included dementia, anxiety, and esophageal reflux. The resident's quarterly Minimum Data Set (MDS), dated 06/24/11, identified severe cognitive impairment, the resident required extensive assistance of one person for eating, and held food in his mouth as a swallowing disorder. Resident #1's Dietary Progress Notes identified a "history of swallowing problems," including the	F 309		

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 309	Continued From page 13 following: *01/10/11 - ". . . Hx [History] 'choking' episodes but nothing recently. . . ." *05/16/11 - ". . . [increased] difficulty swallowing. Some pocketing [with] meals. Will try ground meats. Does have hx. of swallowing problems." Resident #1's current care plan, dated 06/29/11, stated "Problem, Nutritional Status . . . Swallowing problems: Yes, states meat gets 'stuck in throat'. . . Approach . . . Reguar [sic], texture as tolerated . . . Requires ext [extensive] assist of i [one], then may eat part of meal indep. [independently]. . . . Problem . . . Epigastric Distress . . . Approach . . . Encourage resident to sit upright for at least 30 min [minutes] after meals. . . ." The care plan lacked identification of the resident's swallowing problem or approaches for positioning during meals or snacks. Observations of Resident #1 throughout the survey identified the resident seated in a Rock-N-Go wheelchair. This wheelchair has a rocking seat mechanism and is typically positioned reclined approximately 30 degrees from an upright 90 degree position. The rocking mechanism does allow the resident to manually pull him/herself to an upright position. Observations of facility staff assisting Resident #1 during meals and snacks included the following: *07/06/11, 8:22 a.m. - Resident #1 seated in Rock-N-Go wheelchair, reclined approximately 30 degrees. A certified nursing assistant (CNA) (#6) fed him his meal of oatmeal, toast, hard boiled egg, banana, and milk. The resident did eat part of the banana independently. Throughout the meal Resident #1 coughed after taking a bite or	F 309		

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

PRINTED: 07/19/2011
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
	355040	A. BUILDING _____ B. WING _____	07/07/2011

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 309	Continued From page 14 mouthful of a meal item, the CNA would wait for the resident to recover, and continue the meal. *07/06/11, 3:25 p.m. - Resident #1 seated in Rock-N-Go wheelchair, reclined approximately 30 degrees. A CNA (#7) fed him a brownie and a glass of milk. The resident coughed after taking a bite of the brownie, the CNA waited for the resident to clear his throat, and continued with the snack. Throughout these observations Resident #1 pulled himself forward to an upright position, then would return to the reclined position. The CNAs (#6) and (#7) failed to offer to position the resident or the chair upright or transfer the resident to a dining room chair. Observation of meals on 07/06/11 at 12:10 p.m. and 07/07/11 at 8:25 a.m. identified Resident #1 seated in an upright position in a dining room chair and CNAs assisting him and feeding him his meals. The resident did not cough during either of these observations. During interview, on 07/07/11 at 9:00 a.m., an administrative nursing staff member (#5) reported the facility staff transfer Resident #1 to a dining room chair to be seated in an upright position for all meals. Observations on 07/06/11 at 8:22 a.m. and at 3:25 p.m. identified this practice is not consistently followed by facility staff members. Failure to care plan Resident #1's swallowing problems, pocketing of food, and approaches for these problems limited the staff's ability to consistently ensure appropriate seating position during meals and snacks for the resident. Failure to implement upright sitting position during meals	F 309		

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

PRINTED: 07/19/201
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365040	A. BUILDING _____ B. WING _____	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	760 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 309	Continued From page 15 and snacks placed Resident #1 at risk of choking, aspiration, and complications related to these negative events.	F 309		
F 371 SS=E	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, policy and procedure review, record review, and staff interview, the facility failed to store food in a safe and sanitary manner in 1 of 1 kitchen and 2 of 3 unit refrigerators. (B Unit and Meadowlark Special Care Unit). Findings include: Review of the facility's "Food Storage" policy occurred on the morning of 07/07/11. The policy, revised November 1998, stated the following: "'. . . General Food Storage: . . . 2. Containers of food shall be stored a minimum of 6 inches above the floor in a manner that protects the food from splash and other contamination. . . " "'. . . Ready to Eat, Potentially Hazardous Food Disposition: 1. . . . must be discarded after 3 days for ready-to-eat potentially hazardous	F 371	1. Corrective action will be accomplished by: A) Outdated food was thrown out. B) Midwest Refrigeration came out on 7-7-11 and repaired the fan motor (see attachment #4a). C) Removing the Osmolite from the storage room to the kitchen on a rack. D) The food was thrown. 2. A) Residents receiving the resource and mighty shakes have the potential to be affected by this. B) All residents have the potential to be affected by it. C) Only one resident has the potential to be affected by this. D) Any resident receiving food in the freezers with ice packs stored has the potential to be affected by it.	8-11-11

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

PRINTED: 07/19/201
FORM APPROVEC
OMB NO. 0938-039

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 _____	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	760 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 371	Continued From page 16 foods. . . ." Review of the facility's "Food Supply Guidelines" policy occurred on the morning of 07/07/11. The policy, revised November 1998, stated, ". . . General Food Protection: At all times including while being stored . . . food shall be protected from potential contamination, including . . . overhead leakage, or overhead drippage from condensation. . . ." An initial tour of the facility's kitchen occurred on 07/05/11 at 12:00 p.m. with an administrative dietary staff member (#1). Observation showed the following in the: *walk-in cooler - a two quart food storage container of approximately three pounds, sliced, variety, deli meat including bologna and salami, which dietary staff labeled with the date opened, June 27, eight days prior. *walk-in freezer, on a wire shelf beneath the air compressor - ice build up on the top surface of two cases containing four ounce cartons of "Resource Thickened Shakes" and eight ounce cartons of "Mighty Shakes," milk-based supplements. A tour of the environment occurred on the afternoon of 07/05/11. Observation of a mechanical storage room showed cardboard flats containing eight ounce cans, "Osmolyte," a milk-based formula used for tube feedings, stored on the floor. On the afternoon of 07/05/11, observation showed a sign posted on the exterior of the A unit refrigerator's freezer compartment stated, "Please don't put ice cream in this freezer. It	F 371	3. The facility put the following measures in place: A) Dietary all staff meeting will be held 8-4-11 (see attachment #4b). B) Trays have been placed between the food and the condenser at all times (see attachment 4b). C) Osmolite was moved to the kitchen store room, lowest shelf. Will be discussed at the dietary all staff meeting 8-4-11 (see attachment #4b). D) Notes placed on all freezers that store ice packs (see attachment #4c & 4d). Memo put out to all staff 7-26-11 (see attachment #4e). 4. Corrective action will be accomplished by August 11, 2011.	

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

PRINTED: 07/19/201
FORM APPROVE
OMB NO. 0938-039

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 _____	07/07/2011

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 371	Continued From page 17 doesn't stay frozen. We can't store food with ice packs not used for food." A tour of the facility's kitchen and other food storage areas within the facility occurred on 07/06/11 at 9:30 a.m. with an administrative dietary staff member (#1) Observation showed the following in the: *walk-in cooler - the container of deli meat, observed on 07/05/11, remained stored. *walk-in freezer - the cartons of supplements. observed on 07/05/11, remained stored. Removal of the cases from the shelf showed a large icicle extending from the bottom of the air condenser to the wire shelf. Opening of the cases revealed wet areas that had refrozen on the interior surfaces of the cases. *mechanical storage room - the cans of tube feeding formula, observed on 07/05/11, remained stored. *B unit refrigerator's freezer compartment - a Dixie cup of ice-cream stored with six ice packs, including one labeled with the manufacturer's recommendation, ". . . Should be positioned away from the body. . . . ," indicating to be used during resident care. *Meadowlark Special Care Unit refrigerator's freezer - Dixie cups of ice cream and an ice cream bar stored with seven ice packs, including ice packs labeled by the manufacturer as above and an ice pack wrapped with a washcloth. Interviews of a dietary staff member (#2) and an administrative dietary staff member (#1) occurred during the dietary tour. The dietary staff member (#2) stated she was aware of the ice buildup in the walk-in freezer and stated it occurred "mostly on the top shelf." The administrative dietary staff	F 371	5. Our facility plans on monitoring as follows: A) Dietitian, QA coordinator, or designated person will do QA audits 5 times per week for 2 weeks, then 2 times per week for 2 weeks, and then once per week for 2 months (see attachment #4f). B) Dietitian, QA coordinator, or designated person will do QA audits 5 times a week times 2 weeks, 2 times per week for 2 weeks, and 1 time per week for 2 months (see attachment #4g). C) QA coordinator or designated person will do a QA audit once a month for 2 months (see attachment #4h). D) Dietitian, QA coordinator, or designated staff person will audit 5x/week for 4 weeks, then 2x/week for 4 weeks, and then 1x/week for 4 weeks (see attachment #4i).	

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

PRINTED: 07/19/201
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365040	A. BUILDING _____ B. WING _____	07/07/2011

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 371	Continued From page 18 member (#1) agreed facility staff should not store food beyond the required length of storage, should protect food from overhead drippage from condensation, should not store food with ice packs for resident use, and should not store food on the floor of the mechanical storage room.	F 371		