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 _____	08/17/2017

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 08/14/17 and completed on 08/17/17, the sample included 5 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		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157		9/27/17

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

Electronically Signed | 09/08/2017

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 157	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure timely notification of a physician for 2 of 17 sampled residents (Resident #1 and #8) who experienced a change in health status. Failure to promptly notify the physician of Resident #1's elevated blood glucose levels may have resulted in delayed treatment and adverse consequences. Failure to notify the physician of Resident #8's threats of suicide did not allow the physician the opportunity to provide input to ensure his safety and well-being. Findings include: The facility failed to provide a policy regarding notification of the physician of changes in residents' health status.	F 157	For residents #8 and all other residents at Luther Memorial Home who exhibit suicidal behavior or statements a suicide prevention policy has been developed. Also, for residents #1 and #8 and all other residents at Luther Memorial Home that have a deterioration in their physical, mental, or psychosocial status a physician notification policy has been developed. Education on these policies has been given to all nurses at a mandatory meeting on September 7, 2017. All other staff will be given education on the suicide prevention policy on 9/20/17 and 9/21/17.For resident #1 and all other residents with diagnosis of diabetes the nurses were educated on	

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F 157	Continued From page 2 - Review of Resident #8's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/02/17, identified cognition intact. Medical diagnoses included dementia, major depressive disorder, and severe psychotic symptoms. Physician's orders included, Lexapro (antidepressant), Remeron (antidepressant), Abilify (antipsychotic), and Ativan (antianxiety). A hospital discharge summary, dated 08/12/16, identified ". . . major depressive disorder, severe . . . Current stress: Severe r/t medical comorobidities past few months and desire to give up on life, making suicide threats. Loss of independent living. . . ." The current care plan stated, ". . . Mood Disorder . . . Dx [diagnosis]: Major Depressive Disorder, Severe . . . Update family/MD [physician] prn [as needed]. . . . At Risk for Injury/Falls R/T [related to] psychotropic med [medication] use . . . Monitor effectiveness of medication (mood/behavior/depression). Report to MD prn.. . . . Behavior Plan . . . 10/3/16 Call light found wrapped loosely around neck, but res [resident] making comments of killing himself. . . ." The medical record lacked evidence nursing staff notified the physician of Resident #8's verbal and physical threats of suicide noted on 10/03/16, 10/04/16, and 10/05/16. * 10/03/16 at 6:55 p.m., ". . . Resident made comments that he 'wanted to die' and he was going to 'kill himself' . . . CNA notified writer that resident put on call light and when answered it was observed to be wrapped around residents	F 157	blood sugar parameters policy at meeting 9/7/17. For resident #8 Dr. Frank was notified of suicidal behavior on 10/10/16 and was evaluated by Dr. Frank on 10/10/16. Dr. Frank's evaluation stated that resident #8 denied wanting to commit suicide and that resident #8 had no intent plan. Dr. Frank was also notified on 3/15/17 per fax of suicidal statements resident had made to x-wife. Resident #8 primary physician is aware of resident #8's history of suicidal behavior, progress note dated 11/9/16 states "continue to follow with psychiatry". Primary physician was also given update on condition per fax 8/11/17. QA data collection and monitoring will be done by the QA Nurse regarding proper physician notification of significant changes in residents' physical, mental, and psychosocial status starting 8/30/17 daily for 6 months, then weekly for 3 months then monthly for 3 months. QA data collection and monitoring will be completed by the QA nurse regarding proper notification of physician on suicidal behavior daily for 6 months, then weekly 3 months, then monthly for 3 months starting 8/21/17. QA data collection and monitoring for physician notification on parameters of blood sugar levels will be done by QA nurse weekly for 12 weeks then monthly for 3 months then quarterly for 3 quarters. All QA data collected will be reported to the QAPI committee monthly.	

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F 157	Continued From page 3 [sic] neck, but loosely and in no way tight enough to cause harm. . . ." * 10/04/16 at 10:40 a.m., ". . . call light removed from room . . . instructed on reasons for use to include safety and his recent threats of killing himself." * 10/04/16 at 4:18 p.m., " . . . Res heard calling ex-wife . . . yelling at her to come and get him . . . 'if you don't come and get me I'm hanging myself! . . . Social Services updated of behaviors this shift. . . ." * 10/05/16 at 10:47 p.m., ". . . Mood: Resident stating that he wants to die and that he should have hung himself. . . ." * 10/10/16, ". . . Initial visit with [psychiatrist] . . ." This appointment was set up prior to Resident #8's threats of suicide. During an interview on 08/15/17 at 4:00 p.m., a social worker (#15) verified a resident's health care provider should be notified when they threaten to hurt themselves, especially if the resident has a past history of suicidal ideation's. The medical record lacked evidence nursing staff notified the physician of the threats of suicide. The record identified the resident verbalized thoughts and feelings of wanting to die and hurt himself beginning on 10/03/16 and continued through 10/05/16. During an interview on 08/16/17 at 8:45 a.m., an administrative staff member (#4) verified staff are expected to notify the physician either by phone call or fax when they feel a resident maybe in immediate danger. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#3) verified the staff failed to notify the physician.	F 157		

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F 157	Continued From page 4 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included diabetes. During an interview on 08/17/17 at 8:40 a.m., an administrative nurse (#4) stated staff should follow the facility guideline on when to follow up on blood sugar readings. Review of the facility guideline on blood sugar readings stated, ". . . If there are 2 blood sugars > [greater than] 320 within one week, contact the MD via a fax. . . " Review of Resident #1's July 2017 blood sugar readings identified elevated blood sugars and no evidence the physician was notified: *07/11/17: 453 *07/12/17: 389 *07/14/17: 323 *07/15/17: 371 *07/16/17: 338 *07/17/17: 337 *07/19/17: 330 *07/20/17: 331 *07/22/17: 321 *07/23/17: 324 *07/24/17: 407 The facility failed to update the physician on Resident #1's elevated blood sugars for two weeks per the facility guideline.	F 157		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 274		9/27/17

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F 274	Continued From page 5 purpose of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility incorrectly completed a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #1) reviewed who did not qualify for a significant change. Failure to correctly determine the need for a SCSA limited the facility's ability to accurately assess the resident's status and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2016, page 2-22 stated, ". . . A "significant change" is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." - Review of Resident #1's medical record occurred on all days of survey. A significant change Minimum Data Set (MDS), dated	F 274	Resident #1 has had a significant change MDS assessment inactivated on 8/5/17 and quarterly MDS assessment was completed and transmitted on 8/5/17. For Resident #1 and all other residents at Luther Memorial Home the RAI manual section pertaining to significant changes was reviewed with all nurses that complete MDS assessments at meeting held September 6, 2017. QA data collection and monitoring will be done by QA nurse. All MDS assessments will be audited to ensure accuracy of assessment and that correct type of assessment is being done starting 9/1/17 for 12 weeks then 2 random MDS assessments will be audited for accuracy per week for 12 additional weeks, then 4 random MDS assessments will be audited per month for additional 6 months. QA data will be reported monthly to the QAPI committee.	

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F 274	Continued From page 6 08/05/17, identified Resident #1's health status did not meet the criteria of a decline or an improvement in two or more areas for staff to complete a significant change MDS. During an interview on 08/16/17 at 3:40 p.m., an administrative nurse (#3) confirmed Resident #1's MDS, dated 08/05/17, should not have been a significant change MDS.	F 274		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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	F 278		9/27/17

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F 278	Continued From page 7 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 8 of 17 sampled residents (Resident #1, #2, #6, #9, #10, #12, #13, and #17). Failure to code the MDS correctly related to non-medication intervention for pain, hospice care, influenza vaccine, dressing, and weights does not provide an accurate assessment of a resident's current status and needs. Findings include: NON-MEDICATION INTERVENTION FOR PAIN The Long-Term Care Facility RAI User's Manual, revised October 2016, page J-3 stated, "Coding instructions for . . . Received Non-medication Intervention for Pain . . .Code 1, yes: if the medical record contains documentation that a non-medication intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy. . . ." - Review of Resident #1's medical record	F 278	Residents #1,#2,#9,#12,#13,and #17 have had corrections made to their MDS assessments and corrected MDS assessments were transmitted from 8/16/17 through 9/1/17. For all residents at Luther Memorial Home the RAI manual page J-3 related to coding of non-medication interventions for pain was reviewed with all nurses that complete MDS assessments at mandatory meeting held September 6, 2017. Resident #10 has had corrections made to the MDS pertaining to dressing and corrected MDS was transmitted on 8/16/17 and on 9/1/17. For all residents at Luther Memorial Home the RAI manual pages G-3 through G-7 related to proper coding for dressing was reviewed with all nurses that complete MDS assessments at mandatory meeting September 6, 2017. Resident #6 has had corrections made to section K0200B and the corrected MDS was transmitted on 8/17/17. For all other residents at Luther Memorial Home the RAI manual page K-3 was reviewed with the dietary manager at meeting held September 6, 2017. Resident #1 has had corrections made to	

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F 278	Continued From page 8 occurred on all days of survey. The significant change MDS's, dated 05/06/17 and 08/05/17, identified non-medication intervention used during the assessment period. The medical record failed to identify the non-medication interventions used during the assessment period. - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS, dated 03/30/17, identified non-medication intervention used for pain during the assessment period. Resident #2's medical record identified restorative therapy applied heat for pain during the assessment period, but failed to assess the efficacy. The annual MDS dated 06/29/17, identified non-medication intervention used for pain during the assessment period. The medical record failed to identify the non-medication interventions used during the assessment period. - Review of Resident #9's medical record occurred on all days of survey. The significant change MDS, dated 06/21/17, and the quarterly MDS, dated 03/22/17 identified non-medication intervention used for pain during the assessment period. The medical record identified restorative therapy applied heat for chronic back pain, but failed to assess the effectiveness. - Review of Resident #10's medical record occurred on all days of survey. The annual MDS, dated 07/27/17, identified non-medication intervention used during the assessment period. Resident #10's record identified restorative therapy applied heat during the assessment period, but failed to assess the effectiveness. - Review of Resident #12's medical record	F 278	significant change MDS removing resident as receiving Hospice care and corrections were made to the vaccine section of the MDS. Corrected MDS was transmitted on 8/24/17. For all other residents at Luther Memorial Home, the RAI manual page 0-3 was reviewed with all nurses that complete MDS assessments at meeting held September 6, 2017. In addition all nurses that complete MDS assessments were educated on completing the entire MDS accurately in all areas at meeting held 9/6/17. Starting 9/1/17 all MDS assessments will be audited upon completion to ensure that they are coded accurately in all areas and that the correct type of MDS assessment has been done. The MDS will be compared to the prior MDS that was completed for each resident and that MDS is then also audited for accuracy in coding and correct type of MDS having been done for 12 weeks then 2 random MDS assessments per week for an additional 12 weeks, then 4 random MDS assessments per month for 6 months. Data will be reported monthly to the QAPI committee.	

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F 278	Continued From page 9	F 278		

occurred on all days of survey. The quarterly MDS, dated 07/08/17, identified non-medication intervention used for pain during the assessment period. Resident #12's record identified restorative therapy applied heat for pain during the look-back period, but failed to assess the effectiveness.

-Review of Resident #13's medical record occurred August 16-17, 2017. The significant change MDS, dated 06/28/17, identified non-medication intervention used for pain during the assessment period. Resident #13's record identified restorative therapy applied heat for pain during the assessment period, but failed to assess the effectiveness.

- Review of Resident #17's medical record occurred on August 16-17, 2017. The annual MDS, dated 05/14/17, and the quarterly MDS, dated 02/19/17, identified non-medication intervention used for pain during the assessment period. The medical record identified restorative therapy applied heat 3-5 times per week, but failed to assess the effectiveness.

DRESSING

The Long-Term Care Facility RAI User's Manual, revised October 2016, pages G-3 through G-7 stated, ". . . Steps for Assessment: Review the documentation in the medical record for the 7-day look-back period. . . . Coding Instructions: Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts.

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F 278	Continued From page 10 . . . Instructions for the Rule of 3: . . . When an activity occurs three or more times at any on level, code that level. . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, arthritis and pain. The quarterly MDS, dated 04/27/17, identified supervision for dressing. Review of the "Point of Care History" documentation identified Resident #10 required limited assistance 3 times and extensive assistance 2 times for dressing during the assessment period. During an interview on 08/16/17 at 3:36 p.m., a charge nurse (#2) confirmed staff should have coded limited assistance for dressing. WEIGHTS The Long-Term Care Facility RAI 3.0 User's Manual, October 2016, page K-3 stated, ". . . K0200B: . . . Weight . . . Steps for Assessment . . . Base weight on the most recent measure in the last 30 days. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice . . . If the resident's weight was taken more than once during the preceding month, record the most recent weight. . . ." Review of Resident #6's medical record occurred on all days of survey. The quarterly MDSs, dated 02/23/17 and 05/24/17, both identified 178 pounds as the weight in item K0200B. The vitals report documentation identified the following:	F 278		

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F 278	Continued From page 11 * 02/23/17 - Weight 182 pounds * 05/24/17 - Weight 168 pounds The dietary progress notes identified the following: * 02/23/17 - "Quarterly review: Wt. [weight] 181# . . ." * 05/24/17 - "Quarterly review: Wt. 168# . . ." During an interview on 08/16/17 at 2:30 p.m., a dietary manager (#1) verified she documented Resident #6's weight incorrectly on the quarterly MDSs, dated 02/23/17 and 05/24/17. HOSPICE The Long-Term Care Facility RAI User's Manual, revised October 2016, page O-3 stated, ". . . Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. . . ." - Review of Resident #1's medical record occurred on all days of survey. The significant change MDS, dated 05/06/17, identified hospice. Review of the medical record showed Resident #1 discharged from hospice 04/23/17. VACCINATION The Long-Term Care Facility RAI User's Manual, revised October 2016, page O-7 stated, ". . . Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza vaccination season . . . Code 1, yes: if the resident did receive the influenza vaccine in	F 278		

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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 12 this facility during this year's influenza season . . ." - Review of Resident #1's medical record occurred on all days of survey. The significant change MDSs, dated 02/06/17, 05/06/17, and 08/05/17, identified Resident #1 received the influenza (flu) vaccine in the facility. Review of the medical record indicated Resident #1 refused the flu vaccine on 10/04/2016.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		9/27/17

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F 280	Continued From page 13 right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 280		

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F 280	Continued From page 14 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility guidelines, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 5 of 17 sampled residents (Resident #1, #6, #7, #8, and #16). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #6's medical record occurred on all days of survey. The current care plan, stated, ". . . Resident has frequency, voiding small amounts . . . Administer antibiotics: _____ (specify). Evaluate/record/report effectiveness/adverse side effects. . . . Monitor Monitor fluid intake/hydration monitoring of _____ cc [cubic centimeters]/day. . . . Monitor lab work: _____ (specify type and schedule). . . ." The current care plan lacked specific, individualized interventions for urinary frequency and staff failed to fill in the blanks for antibiotics, amount of	F 280	For residents #1,#6,#7,#8,and #16 care plans have been updated to reflect current plan of care. For all residents at Luther Memorial Home an updating care plan policy has been developed. All nurses were educated on updating care plans routinely and the requirements of F tag 280 at September 7, 2017 nursing staff meeting. All resident care plans will be reviewed and updated by 9/27/17. Starting 9/19/17, QA nurse will collect and monitor data by auditing 6 care plans per week for 6 months and then 3 care plans per week for 6 months to ensure that the care plans reflect the current plan of care for the resident. The data will be reported to the QAPI committee monthly.	

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F 280	Continued From page 15 fluids, and lab work. The current care plan stated, ". . . Behavior Plan . . . confused, anxious, wants to go home/leave, . . . Approach . . . Inform Charge Nurse, explain husband is resting (and requests no visits after 8pm) . . ." The progress notes, dated 06/14/17, ". . . informed her husband died today . . ." The current care plan stated, ". . . Alteration in respiratory status . . . Oxygen sats [saturation levels] PRN [as needed]/oxygen as ordered. . . ." During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#3) stated the facility failed to update Resident #6's care plan, remove information that identified the use of an antibiotic [not currently on], and remove the blank lines to individualize the interventions. The nurse manager (#3) verified Resident #6's husband passed away in June 2017. Resident #6's husband lived in the same facility and she wanted to continuously visit him. The facility failed to update the care plan and remove the intervention. The nurse manager (#3) verified Resident #6 is not on oxygen and the facility failed to remove it from the care plan. - Review of Resident #7's medical record occurred on all days of survey. The current care plan, stated, ". . . self care deficit . . . Edema glove to Lt [left] hand on during day. . . ." During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#3) verified Resident #7 refused the use of the edema glove and currently does not have any problems with edema. The facility failed to update the care plan to reflect Resident #7's current status.	F 280		

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F 280	Continued From page 16 - Review of #8's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/12/17, identified, "extensive assistance of two staff member for transfers . . ." The current care plan, stated, ". . . impaired mobility/ambulation r/t [related to] CVA [cerebral vascular accident] . . . Transfer . . . Staff to complete stand/pivot transfers w [with] /minimal assist of 1 w/platform walker. . . ." A physical therapy evaluation/plan of treatment, dated 08/12/16, identified ". . . Stand pivot M/A [maximum assist] X2 [of two] with a platform walker . . ." A progress note, dated 05/08/17, stated, ". . . during a transfer from bed to wheel chair . . . not able to pivot effectively and eased to the ground by the CNA [certified nursing assistant] . . . Resident care plan changed to two person extensive assist with pivot transfers . . ." The current care plan failed to identify the need for a two staff pivot/transfer. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#3) verified Resident #8 required extensive assist of two staff members to stand/pivot. The facility failed to update the current care plan. Resident #8's physical therapy evaluation/plan of treatment/physician order, dated 08/12/16, identified ". . . Significant inversion of L [left] ankle making gait unsafe unless he has AFO [ankle - foot brace to correct alignment and/or provide support] on L ankle. . . ." The current care plan failed to address the use of an AFO during	F 280		

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F 280	Continued From page 17 transfers. Observations on 08/15/17 showed the following: * 11:00 a.m., Two CNAs (#7 & #8) applied a gait belt and transferred Resident #8 from the wheel chair to the recliner The resident's left foot inverted and slid on the floor during the transfer. * 4:15 p.m., Two CNAs (#9 & #10) applied a gait belt and transferred Resident #8 from the bed to the wheel chair. The resident's left foot inverted and slid on the floor during the transfer. * 4:30 p.m., Two CNAs (#9 & #10) applied a gait belt and transferred Resident #8 from the wheel chair to the recliner. The resident's left foot inverted and slid on the floor during the transfer. * 5:50 p.m., Two CNAs (#10 & #12) applied a gait belt and transferred Resident #8 from the recliner to the wheel chair. The resident's left foot inverted and slid on the floor during the transfer. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#8) verified Resident #8 had a physician's order for an AFO for the left foot/ankle and the facility failed to provide and/or place it on the care plan. Resident #8's current care plan stated, ". . . Self Care Deficit R/T: . . . dysphagia . . . Eating: . . . G-Tube [gastric] in place . . ." A progress note, dated 06/14/17, stated ". . . G-tube removed . . ." The facility failed to remove this intervention from the care plan. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#8) verified Resident #8 had his G-tube removed on 06/14/17.	F 280		

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F 280	Continued From page 18	F 280		

- Review of Resident #16's medical record occurred on August 16-17, 2017. The current Activities of Daily Living (ADL) care plan stated, "Dressing; . . . Assist with right leg splint on AM [morning] and off at HS [hour of sleep]. . . ."

Observation on 08/16/17 at 3:04 p.m. showed a certified nurse aide (CNA) (#13) assisted Resident #16 to the wheelchair. The CNA placed a large foam block between the resident's lower thighs and attached a cloth strap to the block with velcro to hold the resident's legs in place. Observation failed to show Resident #16 wore a right leg splint.

During an interview on 08/17/17 at 7:45 a.m., Resident #16 stated she has used the foam block with the velcro strap, but not the right leg splint for several years.

During an interview on 08/17/17 at 8:05 a.m., a nurse administrator (#4) stated Resident #16 used the right leg splint with ambulation, but she is no longer ambulatory. The nurse stated the resident used the foam block for a long time, to keep her knees apart, and staff should have included the foam block on the care plan.

- Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "Problem: ADL SELF CARE DEFICIT . . . Approach . . . Toileting . . . Res [resident] is transferring using transfer bar again. . . . Use of Incontinent Products: YES-xlarge pullups day . . . Problem: AT RISK FOR FALLS R/T PAST HX [history] OF/RECENT FALL . . . Approach: Use of transfer pole, grab bars in BR [bathroom]. Pivot transfer . . . Problem:

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F 280	Continued From page 19 DIABETES MELLITUS . . . Approach . . . Update MD [medical doctor] prn [as needed] for rdgs [ranges] less than 70 or > [greater than] 250. . . ." Observations throughout the survey showed the following: *08/15/17 at 8:11 a.m., 9:15 a.m., and 12:08 p.m.: A certified nursing assistant (CNA) (#18) transferred Resident #1 to the bathroom with a sit-to-stand mechanical lift. Observation showed Resident #1 wore snap underwear with a pad. *08/15/17 at 3:23 p.m.: A CNA (#19) transferred Resident #1 to the bathroom with a sit-to-stand mechanical lift. Observation showed Resident #1 wore snap underwear with a pad. Review of the facility guideline on blood sugar readings, occurred on 08/17/17. This guideline, dated 10/05/11, stated, ". . . If there are 2 blood sugars > [greater than] 320 within one week, contact the MD via a fax. . . " During an interview on 08/16/17 at 5:15 p.m., an administrative nurse (#3) stated Resident #1 trialed the transfer bar but still transfers with the sit-to-stand mechanical lift. The administrative nurse (#3) stated since Resident #1 did not have individualized blood sugar parameters the care plan should specify the facility guidelines. During an interview on 08/17/17 at 8:40 a.m., an administrative nurse (#4) stated she expects staff to update care plans when changes occur.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans	F 281		9/27/17

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F 281	Continued From page 20 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to provide services to meet professional standards of practice for 1 of 2 observations of emergency suction, and 4 of 6 observations of insulin administration. Failure to properly assemble a suction machine in a timely manner may delay emergency treatment care for residents. Failure to follow the manufacturer's specifications for insulin preparation and administration with an insulin FlexPen may result in an inaccurate dose of insulin. Findings include: - On the afternoon of 08/16/17, a nurse (#5) located a suction machine in a clean utility room. The nurse exited the clean utility room at 2:10 p.m. obtained a bottle of sterile water from the supply room, returned and made numerous unsuccessful attempts to correctly assemble the suction machine. After seven minutes elapsed she left the clean utility room to obtain assistance. The nurse (#5) returned with an administrative nurse (#4) who assisted her with the assembly of the suction machine. Facility staff failed to demonstrate appropriate assembly to provide a fully functioning, readily available emergency suction machine.	F 281	For resident #1,#16,#22,#23 and all other residents of Luther Memorial Home receiving insulin via pen injection the insulin administration policy has been updated. All nurses have received education for proper insulin pen use and administration technique at a nurses meeting held 8/22/17. Follow up with nurses that did not attend the meeting will be completed by 9/21/17. Beginning 9/1/17,QA monitoring will be completed by QA nurse by observing nurses priming and administering insulin using the insulin pen 3 times a week for 8 weeks and 1 time per week for 4 weeks until compliance is achieved and sustained. Data collection and monitoring will be done at a minimum of 12 weeks. QA data will be reported to the QAPI committee monthly. For all residents at Luther Memorial Home all nursing staff will be educated on assembly and use of facility suction machine at meeting held September 7, 2017. All nurses were required to assemble and demonstrate use of suction machine at 9/7/17 meeting. Annual training and competency skills testing will be completed with nursing staff on facility suction machine assembly and operation on an annual basis. All newly hired	

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F 281	Continued From page 21 - Review of the Novolog FlexPen manufacturer's specifications occurred on 08/17/17. The manufacturer's specifications stated ". . . Giving the airshot before each injection . . . turn the dose selector to select 2 units. Hold the NovoLog FlexPen with the needle pointing up . . . keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0 . . . a drop of insulin should appear at the tip of the needle . . . leave the needle under the skin for at least 10 seconds after injecting insulin. This will make sure that the full dose has been given . . ." * Observation on 8/15/17 at 3:39 p.m. showed a nurse (#6) primed Resident #22's Novolog FlexPen with the needle pointing downward. The nurse (#6) administered the insulin in Resident #22's left arm and immediately removed the FlexPen. * Observation on 08/15/17 at 4:46 p.m. showed a nurse (#21) primed Resident #23's Novolog Flexpen with the needle pointing downward. The nurse (#21) failed to prime the Flexpen with the needle pointing upward. * Observation on 08/15/17 at 5:05 p.m. showed a nurse (#6) primed Resident #16's Novolog FlexPen with the needle pointing downward. The nurse administered the insulin in Resident #16's left upper arm and immediately removed the FlexPen . * Observation on 08/15/17 at 5:13 p.m. showed a nurse (#6) primed Resident #1's Novolog Flexpen with the needle pointing downward. The nurse then administered the insulin in Resident #1's left lower abdomen and immediately	F 281	nurses will demonstrate competency in suction machine assembly and operation during their orientation period. This competency has been added to the orientation checklist for nurses. QA audits to ensure nurse competency in suction machine assembly and operation will be done with random nurses 2 times per week for 2 months and 1 time per week for 1 month starting 9/18/17. QA data will be reported to QAPI committee monthly.	

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F 281	Continued From page 22 removed the FlexPen Facility staff failed to prime the FlexPen with the needle pointing upward and failed to keep the FlexPen needle under the skin for 10 seconds. During an interview on 08/16/17 at 4:57 p.m., an administrative nurse (#4) confirmed staff should prime the FlexPen in the upright position and hold needle under the skin for several seconds after insulin administration.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		9/27/17

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F 309	Continued From page 23 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: TRANSFERS 1. Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled residents (Resident #8), who had an order for an AFO (ankle - foot brace to correct alignment and/or provide support), received the care and services to attain the highest degree of safety possible during transfers. Failure to provide an AFO brace for the resident's left foot/ankle limits the resident's mobility and safety during transfers, and may be a contributing factor to falls. Findings include: Review of #8's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident with left sided hemiparesis (weakness). The quarterly Minimum Data Set (MDS), dated 05/12/17, identified the resident required extensive assistance of two staff for transfers. The current care plan, stated, "Impaired Mobility/Ambulation r/t [related to] CVA with left sided hemiparesis. . . . Therapies	F 309	Resident #8 was evaluated by PT on 8/21/17 for AFO brace. Doctor's prescription for AFO brace was obtained and sent to Health Care Accessories on 8/22/17 for AFO brace for resident #8. Resident #8 was fitted for AFO brace on 8/22/17. While awaiting arrival of AFO brace an air splint will be used on left ankle to assist with transfers. On 9/6/17 Health Care Accessories notified facility that they can not make AFO brace for resident #8 as there is no medicare or payment source. Standard AFO brace was ordered and put in place on 9/14/17. All nurses will use check off list when therapy orders are received to aide in completion and follow through for all therapy orders. Beginning 9/1/17, for resident #8 and all residents at Luther Memorial Home, the Medicare Nurse will collect and monitor data on all therapy orders for all residents for each therapy order written until treatment and follow up is completed or until order is discontinued. This	

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F 309	Continued From page 24 provided: RT [restorative therapy] . . . Staff to complete stand/pivot transfers . . . Also LE [lower extremity] ROM [range of motion]/strengthening and standing in parallel bars w/assist [with/assist] . . . impaired mobility/ambulation r/t CVA . . . Transfer . . . Staff to complete stand/pivot transfers w/minimal assist of 1 w/platform walker. . . . At Risk for Injury/Falls/R/T Psychotropic Med Use . . . Encourage resident to wear gripper socks or slippers when out of bed . . ." A physical therapy evaluation/plan of treatment/physician order, dated 08/12/16, identified ". . . Treatment Dx [diagnosis]: weakness . . . Stand pivot M/A [maximum assist] X 2 [of two] with walker instructed RT to get resident a platform walker. . . . Significant inversion of L [left] ankle making gait unsafe unless he has AFO [ankle - foot brace] on L ankle. . . ." The facility failed to obtain the AFO as ordered by the physician on 08/12/16, one year prior. The progress notes identified the following: * 03/19/17, ". . . Fallen during transfer from bed to wheel chair . . ." * 05/08/17, ". . . during a transfer from bed to wheel chair . . . not able to pivot effectively and eased to the ground by the CNA [certified nursing assistant] . . . Resident care plan changed to two person extensive assist with pivot transfers . . ." Observation on 08/15/17 identified the following: * 10:15 a.m., a restorative aide (RA) (#20) placed a gait belt, stood Resident #8, and instructed him to grab the parallel bars. The resident's left foot turned inward. The RA reached down and with her hands placed the resident's left foot flat on	F 309	monitoring will continue for 12 months. All physician orders will be audited starting 9/18/17 by QA nurse to ensure all orders are processed, entered into EMAR, added to the care plan and implemented accurately. This audit will be done with all orders for 3 months. On 9/20/17 all therapy staff at Luther Memorial Home and Sanford will be educated on implementation of therapy orders and follow through on all therapy orders at subsequent therapy sessions. Therapy staff will relate all orders to the Medicare Nurse or Unit Manager per PT/OT/SLP check off list as part of the QA process beginning 9/21/17. Education was given to all nursing staff and medicare nurse at September 7, 2017 nursing staff meeting regarding implementation and follow through on all therapy orders. For resident #8 and all other residents at Luther Memorial Home that exhibit suicidal behavior or statements a Suicide Prevention Policy has been developed for use in appropriate circumstances. A Physician Notification Policy has also been developed. All nursing staff will be educated on Suicide Prevention Policy and Physician Notification Policy at mandatory nursing staff meeting on September 7, 2017. All Luther Memorial Home staff received education on the Suicide Prevention Policy on 9/20/17 and 9/21/17. All new staff will be educated on Suicide Prevention Policy during orientation. Suicide Prevention has been added to the orientation checklist.	

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	355040	A. BUILDING _____ B. WING _____	08/17/2017

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 309	Continued From page 25 the floor. The RA continued to hold onto the gait belt and Resident #8 stood for approximately five seconds. Observation showed no AFO brace on the resident's left foot. * 11:00 a.m., two CNAs (#7 & #8) placed a gait belt and transferred Resident #8 from the wheel chair to the recliner. One CNA (#7) placed her right arm under the resident's right arm and held the gait belt with her left hand, and the other CNA (#8) placed his right hand under the gait belt. The two CNAs (#7 & #8) stood the resident with the gait belt and transferred him into the recliner. The resident's left foot turned inwards and slid on the floor. Observation showed the resident unable to bear weight on his legs, and no AFO brace on the left foot. * 4:15 p.m., two CNAs (#9 & #10) placed a gait belt and attempted to transfer Resident #8 from the bed to the wheel chair. During the transfer, the CNAs (#9 & #10) stood Resident #8 with the gait belt. The resident's left foot turned inwards and slid on the floor. Observation showed both knees flexed during the transfer limiting the resident's ability to bear weight, and no AFO brace on the left foot. The CNAs sat the resident back onto the bed and repositioned the wheel chair. The CNAs (#9 & #10) again stood the resident from the bed, utilizing the gait belt, and transferred him into the wheel chair. Resident #8's left foot turned inwards, slid on the floor, and the right foot supported minimal weight. * 4:30 p.m., two CNAs (#9 & #10) transferred Resident #8 from the wheel chair to the recliner. The CNAs (#9 & #10) used the gait belt to lift Resident #8 out of the wheel chair and onto the recliner. The resident's left foot turned inwards and slid on the floor. Observation showed the right foot supported minimal weight during the	F 309	Beginning 8/30/17, QA data collection and monitoring will be completed daily by the QA nurse to ensure suicide precautions are implemented in appropriate circumstances and physician is notified for a minimum of 6 months, then weekly for 3 months, then monthly for 3 months. QA data will be reported monthly to the QAPI committee.	

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F 309	Continued From page 26 transfer, and no AFO brace on the left foot. * 5:50 p.m., two CNAs (#10 & #12) placed a gait belt and transferred Resident #8 from the recliner to the wheel chair. Both CNAs (#10 & #12) used the gait belt to stand the resident and transferred the resident into the wheel chair. The resident's left foot turned inward and slid on the floor. Observation showed no AFO brace on the left foot during the transfer. Resident #8 stated, "Please don't drop me." During an interview on 08/15/17 at 4:30 p.m., a CNA (#9) confirmed Resident #8 did not have an AFO, support and/or brace for the left foot/ankle. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#8) confirmed the physician ordered an AFO for Resident #8's left foot/ankle on 08/12/16 and the facility failed to follow through with the order. BEHAVIORS 2. Based on record review and staff interview, the facility failed to provide 1 of 1 sampled residents (Resident #8), with a diagnoses of dementia and behavioral disturbances, immediate monitoring during a health status change. Failure to to assess and monitor in a timely manner and on a regular basis may have delayed treatment and placed this resident at risk for further harm. Findings include: The facility failed to provide a policy regarding monitoring of a change in a residents' health status.	F 309		

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Review of #8's medical record occurred on all days of survey. Diagnoses included cerebrovascular accident (CVA) with left sided hemiparesis (weakness), major depressive disorder, and severe psychotic symptoms. The significant change MDS, dated 11/12/16, identified mild depression and moderate impaired decision making. Physician's orders included Lexapro (antidepressant), Remeron (antidepressant), Abilify (antipsychotic), and Ativan (antianxiety).

A hospital discharge summary, dated 08/12/16, identified ". . . major depressive disorder, severe . . . Current stress: Severe r/t medical comorbidities past few months and desire to give up on life, making suicide threats. Loss of independent living. . . ."

The current care plan stated, ". . . Mood Disorder . . . Dx [diagnosis]: Major Depressive Disorder, Severe . . . Update family/MD [physician] prn [as needed]. . . . At Risk for Injury/Falls R/T [related to] psychotropic med [medication] use . . . Monitor effectiveness of medication (mood/behavior/depression). Report to MD prn.. . . . Behavior Plan . . . 10/3/16 Call light found wrapped loosely around neck, but res [resident] making comments of killing himself. . . ."

The medical record lacked evidence nursing staff immediately monitored Resident #8 following verbal and physical threats of suicide on October 03-05, 2016 as identified:
* 10/03/16 at 6:55 p.m., ". . . Resident made comments that he 'wanted to die' and he was going to 'kill himself' . . . CNA [certified nursing assistant] notified writer that resident put on call

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F 309	Continued From page 28 light and when answered it was observed to be wrapped around residents [sic] neck, but loosely and in no way tight enough to cause harm. . . ." * 10/04/17 at 10:40 a.m., ". . . call light removed from room . . . instructed on reasons for use to include safety and his recent threats of killing himself." * 10/04/17 at 4:18 p.m., " . . . Res heard calling ex-wife . . . yelling at her to come and get him . . . 'if you don't come and get me I'm hanging myself! . . . Social Services updated of behaviors this shift. . . ." * 10/05/17 at 10:47 p.m., ". . . Mood: Resident stating that he wants to die and that he should have hung himself. . . ." * 10/10/16, ". . . Initial visit with [psychiatrist] . . ." The facility scheduled this appointment prior to Resident #8's threats of suicide. During an interview on 08/15/17 at 4:00 p.m., a social worker (#15) verified staff should monitor the resident closely, especially if the resident has a past history of suicidal ideation. The record identified the resident verbalized thoughts and feelings of wanting to die and hurt himself beginning on 10/03/16 and continued through 10/05/16. During an interview on 08/17/17 at 8:00 a.m., a nurse manager (#3) confirmed staff failed to monitor the resident closely after he verbalized thoughts of self-harm.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		9/27/17

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F 323	Continued From page 29 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: STORAGE OF HAZARDOUS ITEMS 1. Based on observation, staff interview, and review of Material Safety Data Sheets (MSDS), the facility failed to ensure the residents' environment remained as free of accident hazards as possible on 2 of 4 resident units (B and D). Failure to safely store hazardous chemicals and scissors placed cognitively impaired/wandering residents at risk for accidents and injury. Findings include: - Observation on 08/16/17 at 3:00 p.m. with an	F 323	To ensure that all the residents environment at Luther Memorial Home is as free from accident hazards as possible and each resident receives adequate supervision and assistance to prevent accidents, Luther Memorial Home staff immediately placed the scissors in a locked cabinet in D wing tub room, placed a lock on the spill kit tool box and placed housekeeping cart in locked storage room when not in use and not under supervision, Clorox urine remover and Lysol disinfectant spray was immediately moved a locked cabinet in the tub room on B wing. All nurses will be educated on	

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F 323	Continued From page 30 environmental services supervisor (#16) showed the following: * D-wing unlocked tub room: Large scissors in an unlocked cabinet at thigh-high level. * D-wing unlocked clean utility room: Five bags of Isolyser (medical waste encapsulator) in an open and unlocked Spill Kit tool box. * D-wing unlocked soiled utility room: One 7.6 liter container of Stride Citrus HC 3 Neutral Cleaner (floor cleaner), diluted, on top of a housekeeping cart. Review of the MSDS's occurred on 08/17/17 and showed the following: * Isolyser Liquid Treatment System (LTS), "Health Hazard Information: EYE AND SKIN: Direct contact with powder may cause moderate to severe irritation. . . . INHALATION: Powder may produce a drying and irritation of the nose, throat and airways following prolonged or heavy exposure. INGESTION: Nausea, vomiting, diarrhea may occur following ingestion of the powder . . ." * Stride Citrus HC 3 Neutral Cleaner, "Precautionary Statements: CAUSES SERIOUS EYE IRRITATION. Avoid contact with eyes, skin and clothing. . . . May cause irritation to mouth, throat, and stomach. Wear chemical-splash goggles and chemical-resistant gloves. . . ." During an interview on 08/16/17 at 3:00 p.m., an environmental services supervisor (#17) stated staff should not have left the scissors in an unlocked cabinet, locked the Spill Kit box containing Isolyser, and removed the container of cleaning solution from the housekeeping cart prior to storage in a unlocked soiled utility room.	F 323	safe and proper storage of potentially hazardous chemicals, tools and equipment at staff meeting held September 7, 2017. All staff will be trained on safe chemical, tool, and equipment storage on 9/20/17 and 9/21/17. Housekeeping staff were educated on proper storage of chemicals and cleaning carts on 8/18/17. Proper procedure for transferring residents using EZ stand lift will be reviewed with all C.N.A.s at meeting to be held September 14, 2017. C.N.A.s will demonstrate proper use of EZ stand lift during this training. Nursing staff will also be educated on proper use of EZ stand lift for transferring residents at staff meeting September 7, 2017. Beginning 8/30/17, QA data collection and monitoring for proper storage of hazardous chemicals and tools will be completed by QA nurse 3 times per week for 8 weeks and 1 time per week for 4 months. Data collection and monitoring will be done for a minimum of 6 months. Observation of resident #13 and #15 transfers will be done to ensure safety measures are in place for EZ stand use BID for 5 days by QA nurse. Beginning 9/5/17, random resident transfer observations will be completed by QA nurse 3 times a week for 8 weeks and 1 time per week for 8 weeks until complince is achieved and sustained at a minimum of 16 weeks. QA data will be reported monthly to the QAPI committee.	

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F 323	Continued From page 31 During an interview on 08/16/17 at 4:15 p.m., an administrative nurse (#4) verified staff should have locked up the large scissors, the spill kit tool box, and removed the floor cleaner solution prior to storage of the housekeeping cart in the unlocked soiled utility room. During initial tour on 08/14/17 from 6:15 p.m. to 7:35 p.m., observation showed the door to the tub room on unit B open. An unlocked cabinet inside the tub room contained a bottle of Clorox Urine Remover and an aerosol can of Lysol Disinfectant. Review of the MSDS's occurred on 08/17/17 and showed the following: *Clorox Urine Remover: ". . . Health Hazard Data: Eye irritant. This product contains hydrogen peroxide, which may cause temporary skin irritation or skin whitening after prolonged contact with the concentrated product. . . ." *Lysol Disinfectant: ". . . Hazards Identification: Emergency Overview: WARNING: KEEP OUT OF REACH OF CHILDREN. Causes eye irritation. Do not spray in eye, on skin or on clothing. . . ." During an interview on 08/16/17 at 4:57 p.m., an administrative nurse (#4) stated she expects chemicals to be locked up. THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 08/14/16. TRANSFERS USING ASSISTIVE DEVICES 2. Based on observation, review of facility policy and procedure, review of manufacturer's guidelines, and staff interview, the facility failed to	F 323		

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ensure each resident received appropriate use of assistive devices to prevent accidents for 2 of 6 sampled residents (Resident #13 and #15) observed during transfers with a mechanical stand lift. Failure to ensure proper use of a mechanical stand lift during transfers placed the residents at risk for falls.

Findings include:

Review of the facility Policy and Procedure titled, "Mechanical E-Z Standing Lift" occurred on 08/17/17. This policy and procedure, revised 07/05, stated. ". . . See attached EZ-stand lift manual for further instructions and proper use of the lift. . . ." The EZ Way Smart Stand manual, revised 06/17/14, stated, ". . . Press the UP button. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. . . ."

- Review of Resident #13's medical record occurred August 16-17, 2017. The significant change Minimum Data Set (MDS), dated 06/28/17, identified the resident is moderately impaired in decision making and required extensive assistance of two or more persons for transfers. The current care plan stated, ". . . EZ lift [mechanical stand lift] with 2 for transfers . . ."

Observation on 08/16/17 at 3:40 p.m. showed two certified nursing assistants (CNAs) (#12 and #13) transferred Resident #13 from the recliner to the toilet using the mechanical stand lift. The CNAs (#12 and #13) clipped the safety strap loosely around the resident's torso and failed to tighten the safety strap around the resident's torso when the resident rose to a standing

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F 323	Continued From page 33 position. Observation on 08/16/17 at 3:47 p.m. showed two CNAs (#12 and #13) transferred Resident #13 from the toilet to the wheelchair using the EZ stand. The CNAs (#12 and #13) clipped the safety strap loosely around the resident's torso and failed to tighten the safety strap around the resident's torso when the resident rose to a standing position. During an interview on 08/17/17 at 8:42 a.m., a charge nurse (#4) stated facility staff should tighten the torso strap and the facility has provided staff training on the use of the mechanical stand lift. The failure to properly use the mechanical stand lift (EZ stand) as per manufacturer's instructions placed Residents #13 and #14 at risk for falls. - Review of Resident #15's medical record occurred August 16-17, 2017. The quarterly MDS, dated 06/10/17, identified cognition intact and requires extensive assistance of one for transfers. The current care plan stated, ". . . Toileting: Ext [extensive] assist of 1 Uses [sic] EZ lift for transfers . . . Impaired Mobility/Ambulation R/T [related to] Res [resident] is non ambulatory, has restricted mobility of R [right] elbow due to old fx [fracture] . . . Transfers: EXT assist of 1 and s/l [stand/lift] . . ." Observation on 08/16/17 at 5:45 p.m., showed a CNA (#14) transferred Resident #15 from the recliner to the toilet using the stand lift. The CNA placed the safety strap loosely around Resident #15's torso. As the CNA raised Resident #15 to a	F 323		

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F 323	Continued From page 34 standing position she failed to tighten the safety strap around the resident's torso. Observation 08/16/17 at 5:55 p.m., showed a CNA (#14) transferred Resident #15 from the toilet to the recliner with the stand lift. The resident sat on the toilet with the safety strap loosely around her torso. The CNA (#14) raised the resident off of the toilet to a standing position and transferred her to the recliner. The CNA failed to tighten the safety strap around the resident's torso. During an interview on 08/17/16 at 11:10 a.m., a nurse manager, (#3) verified the facility staff are to tighten the safety strap buckled around their torso of each resident during a transfer.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		9/27/17

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F 431	Continued From page 35 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to properly label and/or store all medications in a secure manner on 2 of 6 medication and/or	F 431	In accordance with State and Federal laws, Luther Memorial Home will store all drugs and biological in locked carts allowing only authorized nursing staff to	

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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 431	Continued From page 36 treatment carts (Unit B medication cart and Unit D treatment cart). Failure to store all medications securely may result in unauthorized access to medications and failure to ensure proper labeling of medications may result in medication errors. Findings include: Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing, Concepts, Process, and Practice", 10th ed., Pearson Education, Inc., New Jersey, page 770, stated, "Medication Dispensing Systems . . . Medication cart . . . The nurse either carries a key for the medication cart or enters a special code to open the cart, because it must be kept locked when not in use. . . ." - Observation on 08/15/2017 from 4:30 p.m. to 5:00 p.m. showed an unlocked and unattended treatment cart on Unit D with a bottle of Biofreeze (topical pain medication) on top of the cart. The unlocked cart contained various topical creams and individual doses of solution for inhalation. Observation on 08/16/17 at 4:40 p.m. showed a bottle of Biofreeze on top of the unattended Unit D treatment cart. During an interview on 08/16/17 at 4:47 p.m., an administrative nurse (#4) confirmed all medication carts and treatment carts should be locked when not in use. - Observation during medication pass on 08/15/17 at 3:39 p.m. showed a nurse (#6) prepared and administered medication via gastrostomy tube (G-Tube) route. The medication	F 431	have access to the medications for resident care. Education regarding proper storage and handling of medications will be given to all nurses at meeting September 7, 2017. Beginning 9/7/17, QA data collection and monitoring will be completed by the QA nurse to ensure drugs and biological are secured in locked carts when not under direct supervision of authorized staff. Audits will be done 5 times per week for 4 weeks and 3 times per week for 8 weeks by the QA nurse until compliance is achieved and sustained at a minimum of 12 weeks. Data will be reported monthly to the QAPI committee. The medication cards that were incorrectly labeled for resident #22 were sent to pharmacy and returned with corrected labels on 8/16/17. A process has been developed for relabeling of medication cards when medication orders are changed or medication labels are incorrect. Also, all medications will be checked in by 2 nursing staff on arrival from pharmacy by initialing in medication order log book ensuring medication received is correctly labeled. Nurses will be educated on process on September 7, 2017 at mandatory nurses meeting. Beginning 9/7/17, QA data collection and monitoring will be completed by QA nurse on accuracy of med card labels for 10 random med card labels per week for 8 weeks and 5 random med card labels per week for 4 weeks until compliance is achieved and sustained at a minimum of 12 weeks. QA data will be reported to the	

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 _____	08/17/2017

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LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

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F 431	Continued From page 37 administration record (MAR) and physician's order identified glycopymolate one milligram (mg) twice a day per G-Tube. The pharmacy label on the medication card indicated oral route. The pharmacy label did not match the physician order and the MAR. During the observation, the nurse (#6) verified the pharmacy label contained the incorrect route of administration for the medication.	F 431	QAPI committee monthly.	