| 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 _____ | 08/23/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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 |
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| F 558 SS=D | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 4 sampled residents (Resident #7) observed requiring toileting assistance. Failure to place Resident #7's call light within reach may result in an inability to call for help, discomfort, incontinence, and skin breakdown.<br><br>Findings include:<br><br>Review of Resident #7's medical record occurred on all days of survey. Diagnoses included hemiplegia, hemiparesis, and left hand/wrist with splint due to contractures following a CVA (cerebrovascular accident). Resident #7's current care plan stated, ". . . Resident continues to be extensive assist with mobility and transfers . . . does not ambulate and uses wheelchair for locomotion . . . requires extensive assist with cares . . . use of stand/lift for all transfers-use leg strap to keep LE's [lower extremities] stable in lift . . . keep call light in reach at all times . . . "<br><br>Observation on 08/22/18 at 5:36 p.m. showed Resident #7 lying in his bed. The call light was located next to the wall and not within reach. | F 558 | For resident #7 and all other residents at Luther Memorial Home, a policy has been developed on Accommodation of Need. This policy will be reviewed with c.n.a., transport aid, nursing, dietary, and activity staff by September 18, 2018. Staff will sign an education record once they have reviewed the policy and agree that they have good understanding of the policy. This policy will be implemented September 19th, 2018.<br>QA data collection and monitoring will be done by the QA nurse, or designee, that all residents have their call light within reach, as per policy. QA data will be collected weekly on each shift for 1 month, monthly on each shift for 3 months, and then 10 random call light placements will be checked on varying shifts weekly for 2 months to assure compliance is achieved and sustained. This data will be collected and monitored for a minimum of 6 months. This data will be reported monthly to the QAPI Committee. | 9/27/18 |

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

Electronically Signed | 09/07/2018

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| F 558 | Continued From page 1<br><br>During an interview on 08/22/18 at 5:37 p.m. Resident #7 stated he has been unable to reach his call light since he was laid down at approximately 1:30 p.m. The resident stated this happens a few times a week and he ends up having to call out for help.<br><br>During an interview on 08/22/18 5:39 p.m., an activity staff member (#3) agreed the call light should be within reach.<br><br>During an interview on 08/22/18 at 5:46 p.m., an administrative nurse (#1) stated caregivers need to make sure the call lights are placed within reach. | F 558 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to follow professional standards for 1 of 1 supplemental resident (Resident #83) observed receiving the wrong medication dosage during medication administration. Failure to follow the "Five Rights of Medication Administration" placed all residents at risk for medication errors.<br><br>Findings include: | F 658 | For resident #83 and all other residents at Luther Memorial Home all nurses and c.m.a. staff will be re-educated on Luther Memorial Home's Medication Administration Policy at mandatory inservice meeting Tuesday, September 18th at 3:00pm. All nurses and c.m.a. staff that pass medications to residents will be observed during med pass to 5 residents to ensure that the proper procedure is being followed prior to September 25th, 2018. | 9/27/18 |

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| F 658 | Continued From page 2<br>Review of the facility's policy and procedure titled "Medication Administration" occurred on 08/22/18. This policy, revised July 2018, stated, ". . . 3. Prepare medication for administration, using these rules: a. Observe the Five Rights of Medication Administration . . . iii. Right dosage. . . ."<br><br>Observation during medication administration on 08/22/18 at 8:05 a.m. showed a nursing staff member (#6) prepare medications for Resident #83. The nurse (#6) prepared Senokot 8.6-25 milligrams (mg) from a stock medication bottle. Review of the electronic medication administration record identified Senokot S 8.6-50 mg ordered. The nurse reviewed the order and the medication bottle and confirmed Senokot S (Plus) as the correct medication, and stated she had administered the incorrect dose on previous occasions.<br><br>Review of Resident #83's medical record occurred on 08/22/18 and identified Senokot S (8.6-50 mg) ordered daily.<br><br>During an interview on 08/22/18 at 11:15 a.m., a nurse manager (#1) agreed the nurse failed to ensure the correct dose of Senokot S was administered to Resident #83. | F 658 | QA data will be gathered on compliance of staff with the Medication Administration Policy by completing med pass observations on all nurses and c.m.a. staff that administer medications to residents. 5 observations for each nurse or c.m.a. will be completed every 6 months (January and July) for a minimum of one year to ensure that compliance is achieved and sustained. Observations will be completed by the QA nurse or other Supervisory Nurse as designated per QA Nurse. QA data will be reported monthly to the QAPI Committee. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate | F 689 | | 9/27/18 |

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| F 689 | Continued From page 3<br>supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, operator's instructions, and staff interview, the facility failed to ensure a resident received adequate supervision/assistance to prevent accidents for 1 of 1 sampled resident (Resident #48) observed utilizing a mechanical lift with a seat sling for transfers. Failure to ensure proper use of the stand-lift and seat sling resulted in Resident #48 experiencing discomfort and possible injury/bruising.<br><br>Findings include:<br><br>Review of the facility policy titled "Mechanical E-Z standing Lift" occurred on 08/23/18. This policy, revised July 2005, stated, ". . . To provide a safe means of transferring to prevent injury to resident's . . . Refer to Owner's Manual for specific lift usage. . . ."<br><br>Review of the "EZ Way Smart Stand . . . Operator's Instructions" occurred on 08/23/18. These instructions stated, "The Seat Strap is used for additional lower body support . . . Extend the Seat Strap to its fullest length. Attach the loops at the end of the Seat Strap to the same hooks the harness is attached to, located at the top ends of the EZ Way Smart Stand arms. Make sure the Seat Strap is loosely placed on the backside of the patient. NOTE: The Seat Strap is not a lifting accessory and should not be so taut as to lift the patient during the raising or lowering activity. . . . Slide the Seat Strap under the patient's buttocks. . . ." | F 689 | Observation of resident #48's transfer per standing lift was observed bid for 3 days. Education and any correction needed was done at the time of the observation. For resident #48 an OT evaluation of transfer method has been completed and recommendations will be followed with consent of the resident/family.<br>All residents at Luther Memorial Home that transfer per use of the standing lift will have transfers observed by a supervisory nurse bid for 3 days prior to September 19th, 2018.<br>For resident #48 and all other residents at Luther Memorial Home a Mandatory education and Competency Check Inservice for proper use and operation of standing lifts will be held September 11th, 2018. Education and demonstration will be presented by OT and PT staff.<br>QA data for correct and safe transfers per standing lift will be collected by QA nurse or designee on 6 random residents that transfer using the standing lift twice/week for 12 weeks, once/week for 12 weeks until compliance is achieved and sustained at a minimum of 24 weeks. QA data will be reported to the QAPI Committee monthly. | |

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| F 689 | Continued From page 4<br><br>An observation on 08/21/18 at 10:25 a.m. showed two certified nurse aides (CNAs) (#7 and #8) transferred Resident #48 to the commode from the recliner chair utilizing the EZ stand (mechanical stand lift) and the seat sling. The CNAs placed the seat sling's strap on the outside of the resident's hands/wrists/forearms where it rubbed during transfer. The CNAs lowered the resident onto the commode while the seat sling remained tight. When the CNAs attempted to loosen the strap the resident verbalized ("ow") pain. After toileting, the CNAs transferred the resident back into the recliner with the seat sling still in place. One CNA (#8) pulled the sling from under the resident's buttocks/thighs and stated the sling should have been removed before the resident sat down, because pulling the sling from under the resident might cause injury from friction/shearing. Observation before the transfer showed Resident #48 had a large purple/bluish bruise on her left forearm and a small bruise on the top of her right hand.<br><br>Resident #48's current care plan stated, ". . . Transfers: ext [extensive] assist and s/l [stand lift] with 2 - use buttock strap for transfers if res [resident] not assisting with it. . . ."<br><br>Review of Resident #48's progress notes identified the following:<br>* "08/18/2018 6:49AM Skin: CNA noticed 3 small scratches to the back of res [resident] rt [right] thigh. . . ."<br>* "08/19/2018 3:30AM Bruise: 13cm [centimeters] x [by] 14cm purple bruise noted to (L) [left] forearm. Origin unknown. . . ." | F 689 | | |

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| F 689 | Continued From page 5<br>* "08/22/2018 3:40AM Pain: Resident yelling out at 0315 [3:15 a.m.] c/o [complained of] pain in L) arm . . . ."<br>* "08/22/2018 4:15AM Bruises: RFA [right forearm] measuring 5 x 5.6 cm area that is reddish/blue with a 0.8 x 1 cm area that is black/blue. This smaller black/blue bruise is within the larger reddish/blue area. . . . Dorsum of R) hand; measuring 3.4 x 3 cm and is black/blue . . . CNA noted the bruises while assisting resident during toileting rnds [rounds] during the night; unknown as how resident obtained these bruises. . . ."<br><br>During an interview on the afternoon of 08/22/18, a nurse manager (#1) stated she had just finished the incident investigations for Resident #48's bruises and scratches. The nurse (#1) indicated the incorrect use of the EZ stand with seat sling may have caused the bruises, and the scratches may have been from turning the resident from side to side in bed. She also stated the seat sling belt should have been placed on the inside of the resident's arms, and the seat sling should have been removed before the resident was seated in her recliner.<br><br>Facility staff failed to properly utilize the EZ stand with seat sling during Resident #48's transfer resulting in discomfort and possible bruising. | F 689 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary | F 761 | | 9/27/18 |

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| F 761 | Continued From page 6<br>instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(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.<br><br>§483.45(h)(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling for 1 of 1 supplemental resident (Resident #90) and 1 of 3 medication storage areas (B unit). Failure to label medication with the correct physician orders may increase the risk of receiving an inaccurate dose of medication and/or reduced medication efficacy.<br><br>Findings include:<br><br>Review of the facility policy titled "Process for relabeling medication cards" occurred on 08/23/18. This policy, dated, 09/01/17, stated, " . . . Luther Memorial Home will ensure drugs and biologicals used within the facility are labeled | F 761 | For resident #90 the medication card that was inaccurately labeled was sent back to the originating pharmacy on 8/24/18 for re-labeling and was returned with correct label that includes the medication name, dose, strength, expiration date, route and resident's name according to physician's order.<br>All medication cards for all residents at Luther Memorial Home will be checked for accuracy by September 10th, 2018 and any cards needing label correction will be corrected per the facilities medication re-labeling policy by September 12th, 2018.<br>A QAPI Committee was formed to review | |

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| F 761 | Continued From page 7<br>accurately and in accordance with currently accepted professional pharmacy requirements . . . nurse modifies medication orders in Matrix physician order system . . . medication card is sent back for re-labeling by dispensing pharmacy . . . ".<br><br>Review of Resident #90's physician's order, dated 07/31/18, identified, "Coumadin (Warfarin): No changes in Coumadin dose. Coumadin 5 mg [milligrams] M-W-F and 2.5 mg rest of the week (Sun, Tues, Thurs, Sat)."<br><br>Observation on the afternoon of 08/22/18 of the B unit medication cart showed Coumadin 5 mg Monday and Friday, Coumadin 2.5 mg all other days. During an interview at this time, a staff nurse (#4) agreed the medication label did not match physician orders/<br><br>During an interview on 08/22/18 at 11:30 a.m., an administrative nurse (#1) agreed the Coumadin labels should match physician orders.<br><br>Failure to label medication with the correct physician orders may have resulted in Resident #90 receiving the wrong Coumadin dose since the physician order change on 07/31/18.<br><br>Observation on the afternoon of 08/22/18 of the E-kit in B unit medication room showed one Morphine Sulfate cartridge/injectable 10 mg/ml (milligram per milliliter) laying in a container in the cupboard with no pharmacy label, date, or instructions. It was unclear if the cartridge was opened, used or defective.<br><br>During an interview on 08/22/18 at 3:15 p.m., a | F 761 | medication order changes and the process used for re-labeling medication cards. The re-labeling procedure was revised per the committee recommendations. All nursing and c.m.a. staff will be educated on the procedure at a mandatory staff meeting on September 18th, 2018.<br>All medication order changes will be logged by medical records staff and verification that labels were corrected on all of these medication cards and match EMAR orders will be done weekly for 8 weeks, then 15 random medication cards with medication change orders will be checked weekly for 8 weeks, then 8 random medication cards with medication order changes will be checked weekly for 8 weeks by the QA nurse or designee. This QA data will be collected and monitored for a minimum of 24 weeks until compliance is achieved and sustained. QA data will be reported monthly to the QAPI Committee. | |

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| F 761 | Continued From page 8<br>staff nurse (#4) agreed the Morphine Sulfate should have a pharmacy label and date. | F 761 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of the facility policy, review of a cleaning log, and staff interview, the facility failed to prepare and serve food in a sanitary manner in 1 of 1 kitchen. Failure to ensure the cleanliness of food preparation and storage areas has the potential to result in foodborne illness to resident, staff, and visitors.<br><br>Findings include: | F 812 | For all residents at Luther Memorial Home corrective action was immediately taken. The oven fan was cleaned and new quat sanitizer test strips were ordered. Test strips will be routinely checked for expiration date. Staff will be educated on checking for expiration date on the quat test strips and will be re-educated on the cleaning schedule and the importance of maintaining cleanliness of the kitchen at a mandatory dietary staff | 9/27/18 |

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| F 812 | Continued From page 9<br>Review of the facility policy, "DIETARY DEPARTMENT EQUIPMENT AND UTENSILS" occurred on 08/22/18. This policy, revised 11/98, stated, "To prevent cross contamination . . . surfaces of equipment must be washed, rinsed, and sanitized . . . surfaces of all cooking equipment must be kept free of encrusted grease deposits and other accumulated soil . . . devices to prevent grease . . . from dripping into food . . . to be maintained in a clean and sanitary condition . . . equipment must be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. . . ."<br><br>A final tour of the kitchen occurred on 08/22/18 at 9:33 a.m. Observation showed a dusty and encrusted greasy fan blowing air onto food being prepared. During an interview, the dietary supervisor (#2) stated she expected the staff to clean the fans. When asked how often staff clean equipment, the dietary supervisor (#2) stated staff clean daily and weekly and provided a cleaning log for August 2018 which identified staff inconsistently initialed the log on numerous occasions.<br><br>Failure to ensure cooking equipment is free from dust/debris increased the risk for contamination and may affect all residents who consume food prepared or served in the kitchen.<br><br>Continued observation of the kitchen showed three buckets of sanitizer throughout the kitchen/dining area. A dietary supervisor (#2) identified the solution as Oasis 146 Quat and stated staff use Hydrion test strips to test the quat solution. The Hydrion strips available for staff to | F 812 | in-service on September 10, 2018 and September 11th, 2018. QA data and monitoring will be done by completing twice per month sanitation audits to ensure cleanliness of the kitchen until compliance is achieved and sustained at a minimum of 1 year. | |

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| F 812 | Continued From page 10<br>use to test the solution were outdated with the following dates: 04/15/13, 04/30/12, 02/13/17.<br><br>During an interview on 08/22/18 at 9:38 a.m., two dietary staff members (#2 and #5) confirmed the test strips were outdated.<br><br>Use of expired quat testing strips may result in a sanitizer concentration that is either too weak to sanitize kitchen surfaces or too strong, which may be unsafe or toxic. | F 812 | | |