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 _____	C 09/27/2023

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 The standard Medicare/Medicaid recertification survey started on 09/25/23 and concluded 09/27/23.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure an environment free of accidents and hazards for 1 of 1 resident (#25) with a hot liquid spill and 1 of 1 resident (#9) who smoked cigarettes. Failure to ensure appropriate interventions and assessments for residents drinking hot liquids and smoking may result in serious burns/injuries to residents. Findings include: The facility failed to provide a policy regarding hot liquid spills and completing smoking assessments. - Review of Resident #25's medical record occurred on all days of survey and included a diagnosis of dementia. The care plan stated, ". . . At assist table, for supervision/cuing . . ."	F 689	Plan of Correction □ F689 For resident #25 and all other residents residing at Luther Memorial Home a policy for Hot Liquid Safety has been created and will be implemented. This policy will include a hot liquid risk assessment. Resident # 25 and all residents currently residing at LMH have had the initial hot liquids risk assessment completed and intervention put in place if found to be at risk for hot liquid spills. The risk assessment will be completed for residents at the time of admission, with significant change in condition, with any actual spill and with their annual MDS assessment. The policy will include possible interventions to be implemented. If the resident is determined to be at risk the dietician/dietary manager will be notified to initiate interventions. Interventions will be listed on paper and	10/31/23

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

Electronically Signed | 10/17/2023

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F 689	Continued From page 1 A progress note, dated 09/18/23, stated, " . . . Resident spilt [sic] hot tea on her stomach. No redness noted. Will monitor for 72 hours. . . ." An incident report, dated 09/18/23, identified Resident #25 had spilled hot tea on her abdomen with no injuries. During an interview on 09/26/23 at 3:40 p.m. a dietary manager (#3), stated she was not aware of Resident #25's hot liquid spill and had not put any interventions into place to prevent serious burns and/or injuries. During an interview on 09/27/23 at 8:10 a.m. a licensed nurse (#2) verified the hot liquid spill occurred when Resident #25 was alone in her room with hot tea, which did not have a lid on. During an interview on 09/27/23 at 8:20 a.m. an administrative nurse (#1), confirmed the facility failed to put interventions in place after Resident #25's hot liquid spill. - Review of Resident #9's medical record occurred on all days of survey. An admission assessment, dated 08/14/23, identified the use of tobacco. Diagnoses included reduced mobility, and chronic obstructive pulmonary disease. The care plan stated, "I do smoke cigarettes and am aware that my family can assist me off . . . premises to smoke. . . Lock box in residents [sic] room for tobacco product storage. . . COPD - Alteration in respiratory status - uses O2 [oxygen] continuously. . . is aware that family needs to take her out of facility/off grounds to do this. " During an interview on 09/26/23 at 9:00 a.m.,	F 689	posted by the dietician in the kitchen, on snacks carts and at nurses stations. The dietician updates the resident/interventions list as needed. The dietary department will check temperatures of hot liquids prior to serving. The temperature checks will be documented on the temperature log. If temperatures are too high the hot liquid will be held until the temperature is in safe serving range. Nursing staff will be educated on the new policy and process at a mandatory nursing staff inservice meeting on Thursday, October 19, 2023. The dietician will educate the dietary staff individually on the new policy and the temperature checks and temperature log. Hot liquid temperature check completion will be audited and monitored by the dietician or designee weekly for 8 weeks, and then monthly for 4 months to ensure compliance is achieved and sustained. The Hot Liquid temperature log will be ongoing indefinitely. Hot liquid risk assessment completion audits will be completed by the DON or designee for all current residents residing at LMH, all new admissions, any residents that have a significant change of condition and any resident that has an actual hot liquid spill weekly for 8 weeks, and then monthly for 4 months to ensure compliance is achieved and sustained. If concerns are identified, immediate corrective action, such as education, assessment completion, and implementation of interventions will be	

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F 689	Continued From page 2 Resident #9, stated his/her cigarettes are in a locked box in a drawer of the cupboard and family or staff walk him/her to the front door to leave the facility by him/herself to smoke. During an interview on 09/27/23 at 2:15 p.m., staff member (#2) stated staff could take Resident #9 to the front door to smoke, but were not allowed to go outside with the resident. The staff member (#2) stated residents need to sign in and out when leaving the facility. During an interview on 09/27/23 at 3:10 p.m., an administrative nurse (#1), stated he/she was unaware Resident #9 left the facility to smoke alone and the facility had not assessed the resident's ability to smoke alone. The facility failed to complete a tobacco use assessment for Resident #9 upon admission.	F 689	taken. Audit results will be reported to the QA nurse. The QA nurse will submit a report of the audit results to the QAPI committee at each scheduled monthly meeting. For resident #9 and all other residents of LMH that wish to smoke the facility Smoking Policy has been revised to include requirements for safe smoking practices off of facility grounds. Each resident that wishes to smoke must do so off of facility grounds and is informed of this policy prior to admission during the referral and screening process. This information is included in the LMH admission packet. Nursing will complete a Safe Smoking Risk Assessment to determine the amount of supervision and other measures needed to minimize injury risk related to smoking hazards for any resident that wish to smoke. Resident #9 has had Safe Smoking Risk Assessment completed and interventions have been initiated and documented on resident #9□s care plan. Required safety measures for smoking will be documented on all residents care plans as needed. For residents that wish to smoke, the Safe Smoking Risk Assessment will be completed on admission, with significant change of condition and with the annual MDS assessment. Nursing staff will be educated on the revised policy at a mandatory nursing staff inservice meeting on Thursday, October 19, 2023. QA data collection and monitoring will be	

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F 689	Continued From page 3	F 689	completed by the QA nurse or designee to ensure assessments are completed and safety measures are implemented. Data will be collected for all residents that smoke monthly for 6 months to ensure compliance is achieved and sustained. This data will be reported monthly to the QAPI committee. If concerns are identified immediate corrective action, such as repeat of smoking safety risk assessment, implementation of further safety measures, and further education for staff and resident.	