STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	750 MAIN ST E , MAYVILLE, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 12/29/25 and concluded 12/31/25.	F0000		01/12/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(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 (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. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F0641	POC F641 For resident #10 and all other residents at Luther Memorial Home section M skin conditions will be reviewed for accuracy in coding. Resident #10 quarterly MDS assessment dated 12/23/25 has been modified on 12/31/25 to correctly indicate that the resident did not have a pressure sore on admit. The MDS staff responsible for this section are well educated on criteria for section M accuracy. The MDS staff met and reviewed the coding error and the RAI manual for section M pages M-1 through M-44 on 1/9/26. The MDS staff will review accuracy of section M with each NDS assessment completed to ensure accuracy prior to MDS assessment transmission. MDS staff will complete section M audits on all MDS assessments weekly for 8 weeks, if expectations are met then one MDS assessment per week will be audited for an additional 8 weeks to ensure compliance is achieved and sustained. If inaccuracies are identified they will be corrected prior to transmission of the MDS. Audit results will be reported to the QA nurse. The QA nurse will submit results to the QAPI committee at each monthly meeting. This data will be collected for 16 weeks to ensure compliance is achieved and sustained. Completion date: January 30th, 2026	01/30/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0641 SS = D	Continued from page 1 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 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 17 sampled residents (Resident #10). Failure to accurately complete Section M (Skin Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan, and the care provided to the residents. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, (Version 1.20.1), revised October 2025, page M-24, stated, "M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar . . . M0300F1 Enter the number of pressure ulcers that are unstageable related to slough and/or eschar. Enter 0 if no unstageable pressure ulcers related to slough and/or eschar are present. . . . M0300F2 Enter the number of these unstageable pressure ulcers related to slough and or/eschar that were first noted at the time of admission/entry. . . . Enter 0 if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry." Review of Resident #10's medical record occurred on all days of survey. The progress notes included the following: *09/23/25 at 12:44 p.m., " . . . Skin assessment completed on admission." No pressure ulcer/injury noted or identified in this progress note. *10/03/25 at 01:51 p.m., " . . . Resident's R) [right] and L) [left] big toes had small purple non-blanchable areas to the tips of the toes. Bed cradle added . . ." *12/19/25 at 12:22 p.m., " . . . "WEEKLY SKIN REVIEW: R) great toe had a measurable area on bath day but it has flaked off. Dark pink skin noted that is healed. L) heel measures smaller at 2 x 1.8 cm [centimeter] and skin surrounding is clean, intact, and no dryness noted. Site continues to be closed/unstageable. . . ." The quarterly MDS, dated, 12/23/25, showed the facility coded M0300F1 "2", indicating two unstageable pressure	F0641		

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F0641 SS = D	Continued from page 2 ulcers due to coverage of wound bed by slough and/or eschar and M0300F2, "2", unstageable pressure ulcers present upon admission. During an interview on 12/31/2025 at 9:56 a.m., an administrative nurse (#2) confirmed facility staff coded Resident #10's MDS incorrectly.	F0641		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to ensure food is served in accordance with professional standards for food service sanitation in 1 of 1 kitchen. Failure to ensure proper glove usage when serving food may result in foodborne illness to residents, visitors, and staff. Findings include: The 2022 Food and Drug Administration (FDA) Food Code, pages 61-62, stated, ". . . 3-304.15 Gloves, Use Limitation. (A)If used, SINGLE-USE gloves shall be used	F0812	POC F812 For all residents, staff and visitors at Luther Memorial Home, all dietary serving staff will use single use gloves or tongs when serving food without touching nonfood items as to prevent any foodborne illness. All dietary serving staff will be educated on Luther Memorial Home's policy on proper food handling and glove use related to how to store, prepare, distribute and serve food in accordance with professional standards for food service safety on January 9th, 2026. All serving staff will be observed during a meal serve to ensure that proper procedure is being followed as to not touch any contaminated objects while gloves are on during food serving prior to January 30th, 2026. QA data will be collected on compliance with proper food serving and glove use by completing observations on 5 dietary staff serving food weekly x8 weeks. if observations are complying, then we will watch 6 dietary servers monthly x4 months to ensure compliance is achieved and sustained. Observations will be completed by the QA nurse, dietitian or other designated supervisory staff. QA data will be reported monthly to the QAPI committee. All newly hired staff will be educated on Luther Memorial Home's policy for food handling and glove use. This data will be collected for 6 months to ensure compliance is achieved and sustained. Complete date: January 30th, 2026	01/30/2026

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F0812 SS = E	Continued from page 3 for only one task such as working with READY-TO-EAT FOOD . . . used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. . . ." Observation of the tray line in the main kitchen on 12/30/25 at 11:15 a.m. showed an unidentified dietary staff member shuffled through several resident menus located on a counter with gloved hands and used the same gloved hands and placed sandwiches onto resident meal plates. The staff member failed to change gloves after touching non-food items and before handling ready-to-eat food. During an interview on 12/31/2025 at 9:55 a.m., the dietary manager (#1) confirmed the dietary staff member failed to change their gloves after touching the menus and before plating the sandwiches.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	POC F880 For resident #10 and all other residents at Luther Memorial Home, all CNA's will perform proper handwashing and hand hygiene per LMH policy with all colostomy and perineal cares as to help prevent the spread of infection. All CNA's will be educated on LMH's proper handwashing and hand hygiene policy, colostomy cares policy and perineal cares policy at a mandatory meeting on January 15th, 2026. We will review the proper procedure for hand hygiene and glove use during colostomy cares and perineal cares and after they complete these tasks. Hand hygiene, colostomy and perineal cares education and training are completed with CNA's annually at skills blitz and with new hire orientation. Hand sanitizer is available in all resident rooms. QA data collection and monitoring will be done by QA nurse or designee to ensure all CNA's are performing proper handwashing or hand hygiene while completing colostomy cares or perineal cares on varying shifts. 6 CNA's will be observed weekly for 4 weeks, then 5 CNA's weekly for 4 weeks, then 3 CNA's weekly for 4 weeks, then 6 CNA's monthly x3 months ensuring that CNA's are completing proper hand hygiene and handwashing during colostomy cares or perineal cares. CNA's will be corrected at the time of the observation if not completed accurately. If noncompliance or concerns are	01/30/2026

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F0880 SS = D	Continued from page 4 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to follow standards of infection control for 1 of 6 sampled residents (Resident #10) observed during cares. Failure	F0880	Continued from page 4 identified, immediate corrective action will be taken such as further education of CNA not complying with facility policy or disciplinary action. This data will be collected for 6 months to ensure compliance is achieved and sustained. This data will be reported monthly to the QAPI committee. completion date: January 30th, 2026	

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F0880 SS = D	Continued from page 5 to follow infection control practices regarding hand hygiene during cares has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 685, stated, ". . . Gloves . . . The hands are cleansed each time gloves are removed for two primary reasons: (1) The gloves may have imperfections or be damaged during wearing so that they could allow microorganism entry and (2) the hands may become contaminated during glove removal." Information found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated, 02/27/24, titled "Clinical Safety: Hand Hygiene for Healthcare Workers," stated, ". . . Know when to clean your hands . . . Immediately after glove removal . . ." Observation on 12/30/25 at 9:02 a.m. showed a certified nurse aide (CNA) (#3) complete colostomy care for Resident #10. The CNA (#3) emptied stool from the colostomy bag into a graduate, wiped the colostomy bag, emptied the graduate into the toilet, rinsed the graduate with water, wiped the colostomy bag, removed his/her gloves, and without completing hand hygiene, opened the door and retrieved a new box of gloves. Observation on 12/30/25 at 9:41 a.m. showed a CNA (#3) performed perineal care for Resident #10. The CNA (#3) washed the perineal area, removed gloves, and without completing hand hygiene, removed the foot cradle from the end of the bed. During an interview on 12/31/2025 at 12:48 p.m. an infection control nurse (#2) stated she would expect a staff member to wash hands after removing gloves prior to touching other objects.	F0880		