

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0541 January 15, 2016

Ms. Margaret Brandt, Administrator St Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

Subject: St Lukes Lutheran Care Center - IDR

Provider # 245372 Project # S5372025

Dear Ms. Brandt:

This is in response to your letter of November 12, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F176, F329 and F428 issued pursuant to the survey event 07W211, completed on October 22, 2015.

The information presented with your letter, the CMS 2567 dated October 22, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F176 S/S - E 42 CFR § 483.10 (n) Self-Administration of Drugs: An individual resident may self- administer drugs if the interdisciplinary team has determined that this practice is safe.

#### Summary of the facility's reason for IDR of this tag:

The facility alleges R6, R13, R50 and R32 were assessed to have demonstrated the ability to safely self-administer a nebulizer treatment after set up was provided by the nurse. The facility contends the assessment outcomes were documented in the residents' individual medical records.

#### Summary of facts.

The facility submitted information which indicated the self-administration assessments had been conducted and the identified residents had demonstrated the ability to safely administer the nebulizer medication. The results of the assessments were documented in the individual resident medical record. Therefore, this is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F329 S/S - D 42 CFR § 483.25 (I) Unnecessary Drugs: Each resident's drug regimen must be free from unnecessary drugs.

F428 S/S - D 42 CFR § 483.60 (c) Drug Regimen Review: The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

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St Lukes Lutheran Care Center January 15, 2016 Page 2

### Summary of the facility's reason for IDR of this tag:

The facility alleges R13 received the appropriate as needed (PRN) pain medication as prescribed by the physician in order to effectively manage R13's acute post-operative pain. The facility also alleges R13 received the appropriate dose of pain medication based on R13's verbal complaints of pain as well as the licensed nurse's assessment of R13's pain. The facility also contends the pharmacist reviewed R13's pain medication use and determined R13 complained of and exhibited high level of pain in which nurse assessment concurred. The pharmacist indicated the higher dose of pain medications controlled pain, therefore determined there were no irregularities found during R13's medication regimen review.

#### **Summary of facts:**

The facility submitted documentation which identified R13's acute post-operative pain, pain management and pain assessments which supported the use of R13's PRN pain medication. The facility also submitted R13's monthly pharmacist review form which indicated no irregularities noted. This is not a valid example of a deficient practice under these regulations and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

cc:

Lyla Burkman, Unit Supervisor Licensing and Certification Program Health Regulation Division

Telephone: 218-308-2104 Fax: 218-308-2122

la Burkman

Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager

Licensing and Certification File

Kathryn Serie, Mankato District Office Unit Supervisor

Licensing and Certification File

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PRINTED: 01/15/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245372	B. WING		10	/22/2015	
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 000		correction (POC) will serve	F 00	00			
	enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verificatio  Upon receipt of an acon-site revisit of your	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance. cceptable electronic POC, an facility may be conducted to					
F 441 SS=D	regulations has been your verification. 483.65 INFECTION O SPREAD, LINENS	cial compliance with the attained in accordance with CONTROL, PREVENT	F.å.	11		11/14/15	
	Infection Control Prog safe, sanitary and con	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.					
i	Program under which (1) Investigates, cont in the facility; (2) Decides what proshould be applied to a	blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective					
	prevent the spread of isolate the resident.			TITLE		(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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

11/13/2015

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245372	B. WING			10/	22/2015
	ROVIDER OR SUPPLIER	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE  1219 SOUTH RAMSEY  BLUE EARTH, MN 56013				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				(X5) COMPLETION DATE
F 441	communicable disease from direct contact w direct contact will tran (3) The facility must rhands after each direct hand washing is indic professional practice (c) Linens Personnel must hand transport linens so as infection.	prohibit employees with a see or infected skin lesions with residents or their food, if ansmit the disease. The require staff to wash their part resident contact for which cated by accepted the store, process and set to prevent the spread of the second set to prevent the spread of the second sec	F	441			
	by: Based on observation review the facility fails contact with a wound for 1 of 2 residents (For change. In addition the nebulizer machine be residents (R6, R32) of administration observations.  Findings include: R13's physician order daily dressing change wounds.  On 10/21/15, at 10:20 was completed on leed licensed practical numbers (RN)-A. The formal review of the same complete contact of the same contact of the s	observed during medication			F441 INFECTION CONTROL  On 10/21/15, Director of Nursing met we RN-A. RN-A reported that she did not change her gloves after measuring work because she thought she had not touch the wound while measuring. RN-A state that technically she should have chang her gloves.  On 10/23/15, copies of the facility policand procedure for glove use and the World Health Organization's "Your 5 moments for HAND HYGIENE" handowere posted in each resident care area review by nursing staff.  In order to assure best practice, the Director of Nursing contacted a representative of Salter Labs, manufacturer of nebulizer kits, and	und ned ed ed y	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245372	B. WING_			10/:	22/2015
	ROVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1219 SOUTH RAMSEY  BLUE EARTH, MN 56013				
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F 441	the wound using a p RN-A was observed wound edges during measurement was c residents left leg whitreatment. RN-A was bedding, hem of resiresidents left foot wit completion of the draw of the soiled goned clean gloves.  -Right heel: After LP dressing from R13's the wound using a p RN-A was observed wound edges during measurement of the held residents right the treatment. RN-A bedding, clothing, and gloves.  On 10/21/15, at 10:: gloves had come in during dressing chat the gloves had not be R13's bedding, cloth On 10/22/15, at 10:: (DON) stated the exigling clean item:  Policy and procedure gloves read "Gloves read" Gloves	aper wound measuring ruler. to touch wound bed and measurement. After completed RN-A held file LPN-C completed the sobserved to touch R13's idents left pant leg, and top of the the soiled gloves. After essing change, RN-A gloves, washed hands and solutions.  PN-C removed the soiled right heel RN-A measured paper wound measuring ruler to touch the wound bed and to the measurement. After the wound was completed, RN-A leg while LPN-C completed to was observed to touch R13's and right leg with the soiled  40 a.m. RN-A verified clean contact with the wounds ange on both heels and that been changed before touching aning, and skin.  29 a.m. the director of nursing expectation had been that thanged when soiled prior to solve use dated 6/15/15 to should always be changed and between clean and	F	441	revised the facility procedure for hand-held/mask nebulizer and inhaler spacer cleaning and maintenance to include rinsing in-between each use a with taking pieces apart and placing or cloth to air dry. Per Salter Labs, nebukits will continue to be soaked in antibacterial detergent and warm wate 30 minutes, rinsed and allowed to air on clean cloth at the end of each day. Nebulizer kits will be replaced weekly  Upon hire, all nursing staff receive an orientation to hand hygiene and the pand procedure for glove use. License nurses and trained medication aides to be accountable for following the facility procedure for hand-held/mask nebulizand inhaler spacer cleaning.  All Nursing Department staff member required to attend an in-service session that will cover the following topics:  Policy and procedure for glove use.  Hand-Held/Mask Nebulizer and Inhaler Spacer Cleaning and Mainten Policy and Procedure  The in-service sessions will be held of 11/12/15 and 11/13/15. Staff member who are unable to attend will be responsible for completing a make-up packet.  The RN Infection Control Nurse, on a weekly basis times one month, and the ongoing on a monthly basis, will rand monitor the cleaning of nebulizer equipment to ensure compliance with	llong n a ulizer er for dry . olicy ed will ty's zer s are on se ance in rs	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245372	B. WING _			10/22/2015	
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F 441	DuoNeb (medication bronchi) 3 milliliter (M (QID) for emphysema During observation of on 10/20/15, at 6:51 proom with DuoNeb medication cup and mbe connected, hangin The medication cup c disconnected the moumedication vial into the piece, started the nebresident. LPN-A did nfrom the medication from the viality of the procedure had been emptied are used at 4:00 p.m. and had contained liquid. I procedure had been to cup and mouth piece dry between use, and equipment was cleaned R32's physician order Albuterol nebulizer (use the bronchi) 3 ML soluthours as needed for COn 10/21/15, at 11:03 to enter R32's room.	dated 9/3/15, included used to treat spasm of the L) solution four times a day in medication administration o.m. LPN-A entered R6's redication vial. R6's nebulizer mouth piece were noted to g on the nebulizer machine. Ontained liquid. LPN-A atthpiece, emptied the recup, reattached the mouth pulizer and handed it to the ot empty the residual liquid up prior to pouring ital into the cup.  I.M. LPN-A stated R6's cup and mouth piece should and dried after it was last a verified the medication cup LPN-A stated the facility of disconnect the medication and set them on a cloth to further stated the red and rinsed once daily.  Is dated 9/10/15, included sed for relief of spasm of ution QID and every two copp.  a.m. LPN-B was observed	F 4	facility procedure. Results we to the Director of Nursing. Results we to the Director of Nursing. Results will also be incompleted for the Quality Asserts Assurance Committee.  The Director of Nursing is recoverall compliance with this second for the Quality Asserts Assurance Committee.	Results of the cluded in the eport essment and sponsible for		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPI	
		245372	B. WING			10/:	22/2015
	ROVIDER OR SUPPLIER	ITER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1	(X5) COMPLETION DATE
F 441	disconnected the merplaced them on a close placed them on a close on 10/21/15, at 11:04 nebulizer administrate cleaned or rinsed betthey are cleaned on a cleaned on a cleaned on a cleaned and rins the facility procedure for equipment had been and cleaned and rins the facility follows Ce and Prevention (CDC nebulizer cleaning.  On 10/22/15, at 10:33 pharmacist reported to be rinsed each timbecause the resident touched those pieces chance of bacterial generated and prevention control Prace August 2003 includes same patient, small-venebulizers (in-line and cleaned, disinfected, rinsing is needed) and transmission of micros "This report updates, previously published Prevention of Nosoco The facility Hand-hell Spacer Cleaning and	N-B removed the mask, dication cup and mask and th.  4 a.m. LPN B reported ion equipment was not ween use and stated "but evening shift."  5 a.m. the DON verified the nebulizer medication to let air dry between use ed once daily. DON stated enters for Disease Control C) recommendation for  2 a.m. the consultant nebulizer equipment needed it is used and stated is mouth and nose had is there is an increased rowth.  6 CDC and the Healthcare ctices guidelines dated detween treatments on the volume medication dhand-held) should be rinsed with sterile water (if ad dried in the prevention of corganisms. The report read, expands, and replaces the CDC "Guideline" for	F	441			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245372	B. WING_		10/	22/2015
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 441	Continued From page Bacterial Pneumonia,		F	141		

### Department of Health and Human Services **Centers for Medicare & Medicaid Services**

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245372	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/2/2015
Name of Facility		Street Address, City, State, Zip Code	

ST LUKES LUTHERAN CARE CENTER

77/4

1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(Y4) Item	(	Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y	5) [	Date
ID Prefix	F0441	Correction Completed 11/14/2015	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. # LSC	483.65		Reg. # LSC			Reg. # LSC			_
Reg. #			Reg. #		Correction Completed				Correction Completed -
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ID Prefix Reg. # LSC			Reg. #		Correction Completed	1			Correction Completed -
		wed By	Date:	Signature of Sur	•			Date:	/2015
State Agen Reviewed CMS RO	By KS/kf	fd wed By	1/15/2016 Date:	154 Signature of Sui		,	i	12/02. Date:	/2015
Followup to Survey Completed on:  10/22/2015  Form CMS - 2567B (9-92)				Check for any Unco			the Facility?	<b>YES</b> 'W212	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 07W2

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

A S		PART I - TO BE COMPLETED BY THE				STATE SURVEY AGENCY Facility ID: 00116			
S. PETECHYPE DATE CHANGE CO FONENSHIP   1, PROVIDERS. PUBLIE CATESOCKY   1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	(L1) <b>245372</b> 2.STATE VENDOR OR MEDICAID NO		(L3) ST LUKES LUTHERAN CARE CEN (L4) 1219 SOUTH RAMSEY					Initial     Termination     Validation	2. Recertification 4. CHOW 6. Complaint
8. ACCREDITATION STATUS	(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP			
From (a)	8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC		03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC			ENDING DATE: (L35)
18 SNF	From (a): To (b):  12.Total Facility Beds		X A. In Complian Program R. Complianc1. A  B. Not in Con	nce With equirements e Based On: cceptable POC	gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nnical Personnel Hour RN ay RN (Rural SN Safety Code	6. Scope 67. Medica RF)8. Patient9. Beds/R	of Services Limit al Director Room Size
17. SURVEYOR SIGNATURE   Date :   18. STATE SURVEY AGENCY APPROVAL   Date :   Amala Fiske-Downing, Enforcement Specialist   1/29/2016   (L29)   (L29	18 SNF 18/19 SNF 104	19 SNF						(L15)	
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY  19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: RIGHTS ACT: 2. Ownership/Control Interest Disclosure Simt (HCFA-2572) 2. Ownership/Control Interest Disclosure Simt (HCFA-1513) 3. Both of the Above: 2. Facility is not Eligible (L21)  22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT OF PARTICIPATION BEGINNING DATE ENDING DATE (L24) (L41) (L25) 20. Discussifiaction W/Reimbursement 0.5-Fail to Meet Health/Safety 01-Merger, Closure 0.3-Risk of Involuntary Termination 0.4-Other Reason for Withdrawal 07-Provider Status Change 00-Active 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active 04-Other Reason for Withdrawal 05-Fail to Meet Health/Safety 07-Provider Status Change 00-Active 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active 05-Pail Control Interest Disclosure Simt (HCFA-2572) 2. Ownership/Control Interest Disclosure Simt (HCFA-2572) 2. Ownership/C	_	RKS (IF APPLIC		ANCELLATION	DATE):	18. STATE SUF	RVEY AGENCY	'APPROVAL	Date:
19. DETERMINATION OF ELIGIBILITY  — 1. Facility is Eligible to Participate — 2. Facility is not Eligible — 2. Facility is not Eligible  (L21)  22. ORIGINAL DATE  23. LTC AGREEMENT  OF PARTICIPATION  BEGINNING DATE  (L24)  (L41)  25. LTC EXTENSION DATE:  (L27)  27. ALTERNATIVE SANCTIONS  A. Suspension of Admissions:  (L44)  B. Rescind Suspension Date:  (L45)  28. TERMINATION DATE:  29. INTERMEDIARY/CARRIER NO.  03001  (L28)  30. REMARKS  21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:  20. COMPLIANCE WITH CIVIL RIGHTS ACT:  21. L. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:  24. LTC AGREEMENT  OF PARTICIPATION  (L24)  UDUNTARY  OF LUNTARY  OF LOW INVOLUNTARY  OF PARTICIPATION  OF Fail to Meet Health/Safety  OF PARTICIPATION  OF Fail to Meet Health/Safety  OF PARTICIPATION  OF Fail to Meet Agreement  OF Fail to Meet Agre	Marietta Lee, HFE NE II		1	2/03/2015	(L19) K	amala Fiske-	-Downing, B	Enforcement Sp	<u>pecialist</u> 1/29/2016 (L20)
2. Facility is not Eligible 2. Corner of the Above: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above: 2. Corner of the Above: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above: 2. Corner of the A	PAR	Γ II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OF	R SINGLE S	TATE AGENCY	Y
OF PARTICIPATION 12/01/1986 (L24) (L24) (L41) (L25)  27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) (L27) B. Rescind Suspension Date: (L45)  28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. (L28)  30. REMARKS  10. INVOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active  30. REMARKS	1. Facility is Eligible to Pa	rticipate			H CIVIL	2. 0	Ownership/Contro	ol Interest Disclosure	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L24)  B. Rescind Suspension Date: (L44)  28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.  03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 00-Active  30. REMARKS  31. RO RECEIPT OF CMS-1539  32. DETERMINATION OF APPROVAL DATE	OF PARTICIPATION					VOLUNTARY 01-Merger, Clos	00	<u>INVC</u> 05-Fa	DLUNTARY il to Meet Health/Safety
03001 (L28) (L31)  31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44)  B. Rescind Suspension Date:			03-Risk of Invol	untary Termination	on <u>OTHI</u> 07-Pr	ER ovider Status Change		
	28. TERMINATION DATE:			CARRIER NO.	(L31)	30. REMARKS			
	31. RO RECEIPT OF CMS-1539		2. DETERMINATION	OF APPROVA		DETERMIN	ATION APPF	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245372

January 29, 2016

Ms. Margaret Brandt, Administrator St Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

Dear Ms. Brandt:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 14, 2015 the above facility is certified for:

104 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 104 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 3, 2015

Ms. Margaret Brandt, Administrator St Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

RE: Project Number S5372025

Dear Ms. Brandt:

On November 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 22, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 18, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 22, 2015, effective November 14, 2015 and therefore remedies outlined in our letter to you dated November 4, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

# Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245372	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/2/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
S	LUKES LUTHERAN CARE CENTER	₹	1219 SOUTH RAMSEY	

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0176 483.10(n)		Correction Completed 11/14/2015	ID Prefix			Correction Completed 11/14/2015		ID Prefix	F0428 483.60(c)		Correction Completed 11/12/2015
	465.10(11)				483.25(I)		-			483.60(C)		<u> </u>
ID Prefix	F0441		Correction Completed 11/14/2015	ID Prefix			Correction Completed		ID Prefix			Correction Completed
	483.65			Dag #					Pog #			
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed —
Reg. #							Correction Completed					
Reg. #				D "					Dog #			
Reviewed E	By R	eviewed	Ву	Date:	Signatu	ıre of Sur	veyor:				Date:	
State Agen	cy K	S/kfd		12/03/2	015			154	425			12/02/2015
Reviewed E	By R	eviewed	Ву	Date:	Signatu	ure of Sur	veyor:				Date:	
Followup t	o Survey Comp 10/22/		:			•				Summary of the Facility?	YES	NO

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(Y1) Provider / Supplier / CLIA / Identification Number 245372	(Y2) Multiple Constr A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 11/18/2015
Name of Facility		Street Address, City, State, Zip Code	
ST LUKES LUTHERAN CARE CENTER	?	1219 SOUTH RAMSEY BLUE EARTH, MN 56013	

(Y4) Item	(	Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 10/22/2015	ID Prefix		Correction Completed 10/22/2015		ID Prefix		Correction Completed
Reg. #	NFPA 101		Reg. #	NFPA 101			Reg. #		
LSC	K0154	<del></del>	LSC	K0155			LSC		
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
Reg. #		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		
Reg. #			Reg. #				ID PrefixReg. #		
ID Prefix Reg. # LSC			Reg. #				ID Prefix Reg. # LSC		
Reviewed E	By Review	ved By	Date:	Signature of Sur	veyor:			Date	:
State Agen	cy TL/kfd	<u> </u>	12/03/20	015	35482			11,	/18/2015
Reviewed E	By Review		Date:	Signature of Sur	veyor:			Date	
Followup t	o Survey Completed			Check for any Unco Uncorrected Defic				•	S NO

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(Y1) Provider / Supplier / CLIA / Identification Number 245372	(Y2) Multiple Construction A. Building B. Wing 02 - BU	ILDING 2	(Y3) Date of Revisit 11/18/2015		
Name of Facility		Street Address, City, State, Zip Code			
ST LUKES LUTHERAN CARE CENTER	?	1219 SOUTH RAMSEY BLUE EARTH, MN 56013			

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		(	Correction Completed 0/22/2015	ID Prefix			Correction Completed 10/22/2015		ID Prefix		Correction Completed
Reg. #	NFPA 101			Reg. #	NFPA 101						
LSC	K0154			LSC	K0155				LSC		
		C	Correction				Correction				Correction
			Completed				Completed				Completed
ID Prefix	-			ID Prefix					ID Prefix		
Reg. # LSC				Reg. # LSC					Reg. # LSC		
		C	Correction				Correction				Correction
		C	Completed				Completed				Completed
ID Prefix	-			ID Prefix	-						
Reg. #				Reg. #					Reg. #		
				LSC					LSC		
		C	Correction				Correction				Correction
ID Prefix		(	Completed	ID Prefix			Completed		ID Prefix		Completed
Reg. #				Reg. #					Reg. #		
LSC									LSC		
		C	Correction				Correction				Correction
ID Profix			Completed	ID Profix			Completed		ID Profix		Completed
Reg. # LSC				Reg. # LSC				,	Reg. # LSC		
Reviewed E	Зу	eviewed I	Зу	Date:	Signature	of Sur	veyor:	<u> </u>		Dat	ie:
State Agen	cy T]	L/kfd		12/03/2	015		35482	,		1	1/18/2015
Reviewed E	By Ro	eviewed I	Зу	Date:	Signature	of Sur	veyor:			Dat	e:
Followup t	o Survey Comp	leted on:			Check for any						
	10/22/2	2015			Uncorrecte	d Defic	ciencies (CN	IS-25	67) Sent to	the Facility? YE	S NO

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(Y1) Provider / Supplier / CLIA / Identification Number 245372	(Y2) Multiple Cons A. Building B. Wing	8 ADDITION	(Y3) Date of Revisit 11/18/2015
Name of Facility		Street Address, City, State, Zip Code	
ST LUKES LUTHERAN CARE CENTER	3	1219 SOUTH RAMSEY	

(Y4) Item	(Y:	5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(	(Y5)	Date
		Correction Completed 10/22/2015				Correction Completed 10/22/2015					Correction Completed
	NFPA 101 K0154	_		NFPA 101 K0155				Reg. # LSC			<u>—</u>
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #			Correction Completed		ID Prefix Rea.#			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed —
Reg. #		Correction Completed	Reg. #			Correction Completed					Correction Completed
ID Prefix Reg. # LSC		<u> </u>	Reg. #			Correction Completed					
										T	
Reviewed E		d By	Date:	Signature	of Surv	•				Date:	
State Agen	1 2,100		12/03/2	015		35482	,				18/2015
Reviewed E	By Reviewe	d By	Date:	Signature	of Surv	eyor:				Date:	
Followup t	o Survey Completed o	n:		Check for any Uncorrected						YES	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 07W2

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facility ID: 00116	
MEDICARE/MEDICAID PROVIDE     (L1) 245372     2.STATE VENDOR OR MEDICAID N     (L2) 428540900	ATE VENDOR OR MEDICAID NO.  (L4) 1219 SOUTH RAMSEY (L5) BLUE EARTH, MN  TERCTIVE DATE CHANGE OF OWNERSHIP  7. PROVIDER/SUPPLIER CATEGORY						4. TYPE OF ACT  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint	
(L9)		01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit  8. Full Survey A	9. Other fter Complaint	
6. DATE OF SURVEY 10/2:  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>2/2015</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR EN	IDING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	104 (L18) 104 (L17)	Program Requirements         2. Tec           Compliance Based On:         3. 24          1. Acceptable POC         4. 7-I			And/Or Approved Waivers Of The Following Requirements:  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code  * Code:  And/Or Approved Waivers Of The Following Requirements:  6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room  * Code:  (L12)				
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY M	MEETS			
18 SNF 18/19 SNF 104	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)		
(L37) (L38)  16. STATE SURVEY AGENCY REMARKATION (L38)	(L39) ARKS (IF APPLIC		(L43)	N DATE):					
17. SURVEYOR SIGNATURE  Holly Kranz, HFE NE II		Date :	1/16/2015		18. STATE SUF			Date:	
				(L19)			Enforcement Spe	ecialist 12/03/2015 (L20)	
19. DETERMINATION OF ELIGIBIL  1. Facility is Eligible to F  2. Facility is not Eligible	JTY articipate	20. COM	BY HCFA RE  IPLIANCE WITH  HTS ACT:		21. 1. S 2. C	tatement of Fina	TATE AGENCY  ncial Solvency (HCFA ol Interest Disclosure S ::		
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986	23. LTC AGREE BEGINNING		4. LTC AGREEN		26. TERMINA  VOLUNTARY  01-Merger, Clos	TION ACTION:  00	INVOI	(L30) <u>UNTARY</u> to Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	A. Suspensio	IVE SANCTIONS n of Admissions:	(L25)		02-Dissatisfactio 03-Risk of Invol 04-Other Reason	untary Terminatio	on <u>OTHE</u>	vider Status Change	
(127)	B. Rescind St	uspension Date:	(L45)						
28. TERMINATION DATE:	29	9. INTERMEDIARY	/CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	L DATE					
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 4, 2015

Ms. Margaret Brandt, Administrator St Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

RE: Project Number S5372025

Dear Ms. Brandt:

On October 22, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document:

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233

Fax: (507) 537-7194

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 1, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

St Lukes Lutheran Care Center November 4, 2015 Page 4

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

# FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 22, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

St Lukes Lutheran Care Center November 4, 2015 Page 5

regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245372	B. WING			10/22/2015	
	PROVIDER OR SUPPLIER  S LUTHERAN CARE	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electror be used as verificated.  Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  483.10(n) RESIDENT DRUGS IF DEEMED An individual resident the interdisciplinary §483.20(d)(2)(ii), has practice is safe.  This REQUIREMENT by:  Based on observative review the facility face.	of correction (POC) will serve for compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 are submission of the POC will ion of compliance.  acceptable electronic POC, an air facility may be conducted to notial compliance with the en attained in accordance with en attained in accordance with NT SELF-ADMINISTER D SAFE and may self-administer drugs if team, as defined by as determined that this	F 0		F176 SELF-ADMINISTRATION OF DRUGS	-	11/14/15
	capable to self-adm	ninister medication for 4 of 4 R50, and R32) observed to			St. Luke's Lutheran Care Center's Self-Administration of Medication Po and Procedure and Nebulizer Administration Protocol are well def and comply with applicable requiren	ined	
	DuoNeb (medicatio	ers dated 9/3/15, included in used to treat spasm of the (ML) solution four times a day ma.			Residents who self-administer their medications should be assessed an have demonstrated the ability to set and self-administer medications as	nd	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

11/13/2015

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

TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
				_			
		245372	B. WING			10/2	22/2015
NAME OF I	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
STIUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY		
O' LOIL	O LOTTILITAN OATIL	OLIVIEI		В	LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	7/21/15, indicated if for mobility and to room and corridor. the resident's diagrithe medical record assessment related self-administer medical record assessment related self-administer medication into the the receptacle to the nebulizer machine and attached recept the room.  R13's physician ord DuoNeb 3 ML solut pulmonary disease  During observation on 10/21/15, at 10: to administer a nebulizer receptacle the face mask, turn and placed the mask R13 stated "I'll set my time R13's quarterly MD R13 had been cogrextensive assist for	mum Data Set (MDS) dated R6 required extensive assist move between locations in In addition, the MDS indicated noses included anxiety. When was reviewed, it lacked and to R6's ability to dications.  of medication administration 1 p.m. licensed practical nurse ved to administer a nebulizer PN-A placed the prescribed nebulizer receptacle, attached ne mouthpiece, turned on the and handed the mouthpiece otacle to R6 and walked out of ders dated 10/1/15, included tion QID for chronic obstructive (COPD.)  of medication administration 49 a.m. LPN-B was observed oulizer treatment to R13. Derescribed medication into the e, attached the receptacle to ned on the nebulizer machine sk over R13's nose and mouth. It know what I'm doing." LPN-B mer" and left the room.	F 1	76	prescribed. Residents who may be alone during the course of the nebut reatments but do not set up their medications or initiate their treatment assessed to determine if they are so be left alone during the course of the nebulizer treatment. It is facility pothe resident is assessed for their alkeep the nebulizer mask on or han mouth piece in place throughout the treatment. Nursing staff set a time when the nebulizer treatment is due done and check to assure that the treatment is completed before shut the machine. If the resident demonthe capability of being left alone ducourse of the nebulizer treatment, at the treatment is obtained and a care plane written in this regard and reviewed quarterly by the interdisciplinary teather 4 residents cited in this deficient. Documentation of an assessment, physician order and care plan entry reviewed quarterly by the interdisciplinary team is in place.  Nursing staff members involved in administering medications are accountable for following the facility regarding self-administration of medications and the nebulizer administration protocol.  Nursing Department staff members	ents are eafe to he licy that bility to deheld e refor the to be ting off histrates ring the a note he cian's her he cian's her	
	extensive assist for dependence to mo				administration protocol.  Nursing Department staff members required to attend an in-service tha		

F 176 Continued From page 2 reviewed, it lacked an assessment related to R13's ability to self-administer medications.  FREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 176  Cover the following topics:  1. Review of facility Self-Administration of Medications Policy and Procedure		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
ST LUKES LUTHERAN CARE CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE			245372	B. WING		10/:	22/2015
F 176 Continued From page 2 reviewed, it lacked an assessment related to R13's ability to self-administer medications.  FREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 176  Cover the following topics:  1. Review of facility Self-Administration of Medications Policy and Procedure				1	219 SOUTH RAMSEY		
reviewed, it lacked an assessment related to R13's ability to self-administer medications.  cover the following topics: 1. Review of facility Self-Administration of Medications Policy and Procedure	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE
R50's physician orders dated 10/8/15, included DuoNeb 3 ML solution QID for COPD.  During observation of medication administration on 10/21/15, at 11:01 a.m. LPN-B was observed to administer a nebulizer treatment to R50. LPN-B placed the prescribed medication into the nebulizer receptacle, attached the receptacle to the mouthpiece, turned on the nebulizer machine and handed it to R50. LPN-B stated "I have my timer on" and walked out of the room.  R50's quarterly MDS dated 7/10/15, identified R50 had been cognitively impaired, required extensive assist for activities of daily living, and total dependence to move between locations in room and corridor. When the medical record was reviewed, it lacked an assessment related to R50's ability to self-administer medications.  R32's physician orders dated 9/10/15, included Albuterol nebulizer (used for relief of spasm of the bronchi) 3 ML solution QID and every two hours as needed for COPD.  On 10/21/15, at 11:03 a.m. LPN-B was observed to enter R32's room. R32 was sitting in a wheelchair, with a nebulizer machine and hands a wheelchair, with a nebulizer machine and handed it to R50's ability to self-administration on the nebulizer and walked out of the room.  R32's quarterly MDS dated 8/28/15, indicated R32 required extensive assist for activities of	F 176	reviewed, it lacked R13's ability to self R50's physician or DuoNeb 3 ML solud During observation on 10/21/15, at 11: to administer a net LPN-B placed the nebulizer receptace the mouthpiece, tu and handed it to Fitimer on" and walk R50's quarterly MER50 had been cogextensive assist for total dependence to the room and corridor. The reviewed, it lacked R50's ability to self R32's physician or Albuterol nebulizer the bronchi) 3 ML shours as needed for On 10/21/15, at 11 to enter R32's room wheelchair, with a nose and mouth, a from the nebulizer turned off the neburoom.	an assessment related to f-administer medications.  ders dated 10/8/15, included tion QID for COPD.  of medication administration 01 a.m. LPN-B was observed oulizer treatment to R50. prescribed medication into the le, attached the receptacle to rned on the nebulizer machine R50. LPN-B stated "I have my ed out of the room.  OS dated 7/10/15, identified nitively impaired, required r activities of daily living, and o move between locations in When the medical record was an assessment related to f-administer medications.  ders dated 9/10/15, included (used for relief of spasm of solution QID and every two or COPD.  :03 a.m. LPN-B was observed m. R32 was sitting in a nebulizer mask covering the mist had been noted coming LPN-B removed the mask, ulizer and walked out of the	F 176	cover the following topics:  1. Review of facility Self-Admin of Medications Policy and Proced 2. Review of facility Nebulizer Administration Protocol The in-service sessions will be h 11/12/15 and 11/13/15. Staff me who are unable to attend will be to complete a make-up packet.  The RN Education Coordinator, Shift Coordinator and Night Shift Coordinator or their designees we observe at least one random me pass monthly to ensure that nursure following the facility policy for nebulizer administration. Results reported to the Director of Nursing guide future compliance monitor training. In addition, the results we summarized at the quarterly Quarterly Quarterly Assessment and Assurance Conference of Meeting. After 1 year, the Qualit Assessment and Assurance Conference of Nursing is responsible.	eld on embers required  Evening fill dication sing staff res will be ality nmittee yunmittee quency oring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/:	22/2015
	PROVIDER OR SUPPLIER  S LUTHERAN CARE	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
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F 176	side of the body. W reviewed, it lacked R32's ability to self-On 10/22/15, at 8:2 (RN)-A indicated th assessment for new observation the result administration equipated a nurse's normedical record to it and left it on. RN-A assessment we just and don't take it off and R32's had not lidetermined safe by On 10/22/15, at 10: (DON) verified the fobservation that the nebulizer administration admini	Then the medical record was an assessment related to administer medications.  22 a.m. registered nurse e facilities self-administration oulizer use consisted of an ident left nebulizer pment on when in use. RN-A te would be entered in the dentify they had been observed stated "It's not a full t make sure they leave it on." RN-A verified R6, R13, R50, been assessed and the interdisciplinary team.  207 a.m. the director of nursing facility practice had been excepted resident did not remove ation equipment while in use. Firstion as self-administration assessed.  232 a.m. the consulting a resident could be left alone betermined appropriate and needed to be a process to mental and functional status of sed.  24 cation administration policy not include nebulizer tion.  25 EGIMEN IS FREE FROM	F 1				11/14/15
SS=D							

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F 329	unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its usadverse consequents should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs as diagnosed and crecord; and resider drugs receive grad behavioral intervents.	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 329				
	by: Based on interview facility failed to esta needed (PRN) pair residents (R13) rew medications. Findings Include: R13 was admitted admission face she	NT is not met as evidenced  y, and document review, the ablish parameters for as medication for 1 of 6 iewed for unnecessary  to the facility on 1/27/14, the set revealed diagnoses to ssure ulcer of right and left		F329 DRUG REGIMEN IS FREE UNNECESSARY DRUGS  Medications were reviewed for R15 Frequent pain assessments were order to manage resident's pain por fractures/sprain/heel ulcers. For eassessment, nursing staff complet pain flow sheet every shift for 5-7 Pain assessments were initiated to determine effectiveness of pain	3. done in ost ach pain ed a days.		

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F 329	heel.  R13's quarterly Mir 9/24/15, identified I R13's physician ord Tylenol (non-narco milligrams (mg) two needed (PRN) for physician order also to give one or two	nimum Data Set (MDS) dated R13 was cognitively impaired.  ders dated 10/1/15, included tic pain medication) 325 to tablets every four hours as pain, and oxycodone (opioid of 2 tablets every four hours and pain. The physician orders of when to give a non-narcotic on versus when to give an N pain medication. The olacked parameters of when tablets of oxycodone.  Attion administration record RN oxycodone had been two (32) times from 10/2/15 Review of documentation for administrations, two tablets IAR included a pain scale for om 1-10 (least-most). Tratings documented on the en 5 and 10, with multiple R13 had been administered 2 ne. Parameters were not g when to administer one (1) when R13 rated the pain. PRN ministered during this time.  12 a.m. licensed practical nurse re were no parameters for LPN-B was unable to identify ave given the PRN Tylenol vs ave administered one or two	F 329	management plan when resident hadjustments in pain medication. B verbal and nonverbal pain ratings obtained from the resident as well intervention and response. Resu flow sheet were reviewed by the Resident Care Coordinator and a management plan was written.  Based on these findings, the resid physician gave the following order parameters for pain medication or 10/23/15: Oxycodone 5mg po 1 ta pain 1-4; 2 tabs for pain 5-10 ever hours prn.  Licensed nursing staff members a accountable for following the facility process for establishing prn pain medication parameters.  All Nursing Department staff mem required to attend an in-service set that will cover the following topics: 1. Review of process for establis pain medication parameters  The in-service sessions will be hel 11/12/15 and 11/13/15. Staff mem who are unable to attend will be responsible for completing a make packet.  A consultant pharmacist reviews Stake's Lutheran Care Center residence of the attending physician Nursing Department staff; a summ his findings is reported to the Qua Assessment and Assurance Committed.	oth were as ts of the N pain ent's with ab for y 6  re ty bers are ssion hing prn d on abers e-up st. dent ee n and nary of ity	

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F 329	(RN)-A verified PRI and oxycodone had medical record and Tylenol had not bee 10/21/15. RN-A state unable to understare.  On 10/22/15, at 10: verified the above a range the order wo On 10/22/15, at 10: pharmacist verified medication needed order.  Request made for a medication administ 483.60(c) DRUG RIRREGULAR, ACT  The drug regimen or reviewed at least or pharmacist.  The pharmacist muthe attending physical nursing, and these	86 a.m. registered nurse N parameters for PRN Tylenol d not been found in the I further verified the PRN en given from 10/2/15 through ated R13 would have been and a pain scale rating.  202 a.m. the director of nursing and stated if there is a dose uld need to be specific.  232 a.m. the consultant parameters for PRN I to be included in the physician current policy on PRN pain stration was not provided. EGIMEN REVIEW, REPORT	F 32	on a monthly basis, the Director Nursing or her designee will rand monitor resident records for unned drugs, to assure compliance with Unnecessary Drug regulation. Ruse summarized at the quarterly Cassessment and Assurance Commeeting. After 1 year, the Quality Assessment and Assurance Commill reevaluate the need and frequentinued compliance monitoring. The Director of Nursing is responsiverall compliance with this regulation.	omly cessary F329 esults will duality mittee mittee uency for sible for	11/12/15
	by: Based on interview	v and document review the ure the consultant pharmacist		F428 DRUG REGIMEN REVIEV	I	

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SI LUKE	S LUTHERAN CARE	CENTER		BLUE EARTH, MN 56013		
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F 428	Continued From pa	age 7	F 42	8		
	needed) pain medi	ameters for use of PRN (as cation for 1 of 6 residents unnecessary medications.		Medications were reviewed for Frequent pain assessments we order to manage resident's pair fractures/sprain/heel ulcers. For assessment, nursing staff com	re done in n post r each pain	
	_			pain flow sheet every shift for 5	-7 days.	
	admission face she	to the facility on 1/27/14, the eet revealed diagnoses to essure ulcer of right and left		Pain assessments were initiated determine effectiveness of pair management plan when reside adjustments in pain medication verbal and nonverbal pain ratin	nt had . Both	
	9/24/15, identified	nimum Data Set (MDS) dated R13 was cognitively impaired.		obtained from the resident as wintervention and response. Reflow sheet were reviewed by the	vell as sults of the RN	
	Tylenol (non-narco milligrams (mg) two	ian orders dated 10/1/15, included Resident		Resident Care Coordinator and management plan was written.	·	
	narcotic) 5 mg, 1 to PRN for breakthrou	pain, and oxycodone (opioid by 2 tablets every four hours by pain. The physician orders		On 11/12/15, the Director of Nureviewed survey findings with a pharmacist. Consultant pharm	onsultant acist stated	
	PRN pain medicati	of when to give a non-narcotic on versus when to give an N pain medication. The		his record review showed the for R13 complained of and exhibited level of pain; nursing assessment	ed of and exhibited a high nursing assessments igher level of pain. Higher esic was administered due evel of pain. He stated that offirmed that the higher dose controlled pain, therefore he	
		o lacked parameters of when tablets of oxycodone.		detected the higher level of pai dose of analgesic was adminis to the higher level of pain. He		
	(MAR) revealed PF administered thirty	tion administration record RN oxycodone had been two (32) times from 10/2/15 Review of documentation for		monitoring confirmed that the hof analgesic controlled pain, the did not feel there were any irre		
	thirty (30) of the 32 were given. The M R13 to rate pain fro	e 32 administrations, two tablets he MAR included a pain scale for in from 1-10 (least-most).		The consultant pharmacist revi Luke's Lutheran Care Center records monthly, looking for me	esident edication	
	MAR varied between areas left blank wh	ratings documented on the en 5 and 10, with multiple en R13 had been administered one. Parameters were not		irregularities. The consultant p will report findings to the attend physician and the Director of N an ongoing basis, the Consulta	ing ursing. On	
	identified, indicating	g when to administer one (1) hen R13 rated the pain. PRN		Pharmacist's report will be sum the quarterly Quality Assessment	marized at	

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F 428	Continued From pa Tylenol was not adr	ge 8 ninistered during this time.	F 4	28	Assurance Committee Meeting.	<b>g</b> .	
	form reviewed. On	Pharmacy Medication Review 10/6/15 the consultant d R13's record, no problems			The Director of Nursing is responsi overall compliance with this regulat		
	(DON) stated she we pharmacist to identify	02 a.m. the director of nursing vould have expected the ify and report PRN parameters for use.					
F 441 SS=D	,		F 4	41			11/14/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.					
	Program under which (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a re	ad of Infection ion Control Program esident needs isolation to of infection, the facility must					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER  ST LUKES LUTHERAN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013			
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F 441	communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must ha	t prohibit employees with a case or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44	41			
	by: Based on observat review the facility fa contact with a wour for 1 of 2 residents change. In addition nebulizer machine residents (R6, R32) administration obse Findings include: R13's physician ord daily dressing chan wounds.  On 10/21/15, at 10: was completed on licensed practical n	ition, interview, and document ailed to change gloves after and during a dressing change (R13) observed for a dressing the facility failed to clean a between use for 2 of 4 observed during medication ervation.  Ider dated 10/12/15, included ge to left and right heel  20 a.m. a dressing change left and right heel wounds by urse (LPN)-C and registered following was observed:		F441 INFECTION CONTROL  On 10/21/15, Director of Nursin RN-A. RN-A reported that she change her gloves after measu because she thought she had rethe wound while measuring. RN that technically she should have her gloves.  On 10/23/15, copies of the faciliand procedure for glove use an World Health Organization's "Y moments for HAND HYGIENE" were posted in each resident careview by nursing staff.  In order to assure best practice Director of Nursing contacted a representative of Salter Labs,	did not iring wound not touched N-A stated e changed lity policy od the four 5 handout are area for		

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F 441	dressing RN-A put the wound using a RN-A was observed wound edges durin measurement was residents left leg witteatment. RN-A was bedding, hem of residents left foot woompletion of the dremoved the soiled donned clean gloverall residents left foot woompletion of the dremoved the soiled donned clean gloverall residents right the wound using a RN-A was observed wound edges durin measurement of the held residents right the treatment. RN-A bedding, clothing, a gloves.  On 10/21/15, at 10: gloves had come in during dressing chartness and come in during dressing chartness and come in during dressing chartness and come in during dressing chartness bedding, clothon, stated the e gloves were to be concluded to the policy and procedured gloves read "Glove"	on clean gloves and measured paper wound measuring ruler. It to touch wound bed and g measurement. After completed RN-A held hile LPN-C completed the as observed to touch R13's sidents left pant leg, and top of with the soiled gloves. After ressing change, RN-A gloves, washed hands and es.  PN-C removed the soiled sight heel RN-A measured paper wound measuring ruler. If to touch the wound bed and g the measurement. After e wound was completed, RN-A leg while LPN-C completed a was observed to touch R13's and right leg with the soiled and right leg with the soiled and the contact with the wounds ange on both heels and that been changed before touching hing, and skin.	F	141	manufacturer of nebulizer kits, and revised the facility procedure for hand-held/mask nebulizer and inha spacer cleaning and maintenance to include rinsing in-between each use with taking pieces apart and placing cloth to air dry. Per Salter Labs, nekits will continue to be soaked in antibacterial detergent and warm with 30 minutes, rinsed and allowed to a on clean cloth at the end of each did Nebulizer kits will be replaced weel.  Upon hire, all nursing staff receive orientation to hand hygiene and the and procedure for glove use. Licer nurses and trained medication aide be accountable for following the fact procedure for hand-held/mask neb and inhaler spacer cleaning.  All Nursing Department staff member required to attend an in-service sest that will cover the following topics:  1. Policy and procedure for glove 2. Hand hygiene 3. Hand-Held/Mask Nebulizer and Inhaler Spacer Cleaning and Maint Policy and Procedure The in-service sessions will be held 11/12/15 and 11/13/15. Staff member who are unable to attend will be responsible for completing a make-packet.  The RN Infection Control Nurse, or weekly basis times one month, and ongoing on a monthly basis, will ramonitor the cleaning of nebulizer	e along g on a abulizer rater for air dry ay. Aly. an e policy as will cility's ulizer bers are sion use denance denan	

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	PROVIDER OR SUPPLIER  S LUTHERAN CARE	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	DuoNeb (medication bronchi) 3 milliliter (QID) for emphyser (QID) for emphyser During observation on 10/20/15, at 6:50 room with DuoNeb medication cup and be connected, hange The medication cup disconnected the medication vial into piece, started the noresident. LPN-A did from the medication from the Medication from the medication medication from the medication have been emptied used at 4:00 p.m. a had contained liquic procedure had been cup and mouth piece cup	on same patient."  PMENT:  Pres dated 9/3/15, included n used to treat spasm of the (ML) solution four times a day ma.  of medication administration in p.m. LPN-A entered R6's medication vial. R6's nebulizer is mouth piece were noted to ging on the nebulizer machine. It contained liquid. LPN-A couthpiece, emptied the inthe cup, reattached the mouth ebulizer and handed it to the into tempty the residual liquid in cup prior to pouring evial into the cup.  B. p.m. LPN-A stated R6's in cup and mouth piece should and dried after it was last indiversified the medication cup in the disconnect the disconnect the medication cup in the disconnect the disc	F 4	.41	equipment to ensure compliance w facility procedure. Results will be not to the Director of Nursing. Results random audit will also be included quarterly Infection Control Report prepared for the Quality Assessment Assurance Committee.  The Director of Nursing is respons overall compliance with this regular.	eported of the in the nt and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY IPLETED
		245372	B. WING			10/	22/2015
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER		STREET ADDRESS, CITY, STATE, 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 441	nose and mouth. Ledisconnected the mplaced them on a complete of the mplaced or insed by they are cleaned or on 10/22/15, at 10: facility procedure for equipment had been and cleaned and ring the facility follows on and Prevention (Complete of the mouth of the mplace of the mouth of the mouth of the mplace of the mp	PN-B removed the mask, redication cup and mask and loth.  O4 a.m. LPN B reported retirement was not etween use and stated "but revening shift."  25 a.m. the DON verified the reported redication in to let air dry between use ased once daily. DON stated renters for Disease Control DC) recommendation for  32 a.m. the consultant denebulizer equipment needed redicated it is used and stated rest mouth and nose had rest there is an increased	F4	41			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DAT	E SURVEY MPLETED
		245372	B. WING		10.	/22/2015
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP C 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa 3/2014 included "Pi Bacterial Pneumon	revention of Nosocomial	F 4	41		

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245372

B. WING

10/22/2015

NAME OF DROVIDED OR SUDDIVED

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
CT L LIVE	S LUTHERAN CARE CENTER			19 SOUTH RAMSEY	
SILUNE	S LUTHERAN CARE CENTER		В	LUE EARTH, MN 56013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 0	00		
	FIRE SAFETY	ē			
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.				
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.				
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Lukes Lutheran Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.  PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:			EPOC	
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or  Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE

Electronically Signed

11/13/2015

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

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CENTER	KS FOR MEDICARI	E & MEDICAID SERVICES				JIVID INO.	0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245372	B. WING			10/	22/2015
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			I219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenma	state.mn.us and	K	000			
	DEFICIENCY MUS FOLLOWING INFO						LE 8
	A description of to correct the defica-	what has been, or will be, done iency.					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					127
	was constructed a The original buildir one-story in height	ng was constructed in 1963, is t, has a partial basement, is protected, and was determined			(s		al e. i
	The 1969 building has no basement, and was determine construction; The 1975 building	addition is one-story in height, is fully fire sprinkler protected, ed to be of Type II (111)  addition is one-story in height, is fully fire sprinkler protected					
	detection in the co	ire alarm system with smoke rridors and in all spaces open hich is monitored for automatic tification.					

Facility ID: 00116

	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	MR MO.	0938-0391
	STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
			245372	B. WING		——————————————————————————————————————	10/2	22/2015
1	NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		×
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 154	The facility has a ca	apacity of 112 beds, and had a		000 154			10/22/15
2.00	SS=D	out of service for m period, the authority and the building is a watch system is pro unprotected by the	nutomatic sprinkler system is lore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire byided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1					
		Based on documer interview, where a resystem is out of ser a 24-hour period, this notified, and the lapproved fire watch parties left unproted	s not met as evidenced by: ntation review and staff required automatic sprinkler rvice for more than 4 hours in ne authority having jurisdiction building is evacuated or an n system is provided for all cted by the shutdown until the as been returned to service.	8		St Luke's Lutheran Care Center  POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE Page 1 of 3  APPROVED BY: Margaret Brandt Effective Date: 10/22/15	ON	
		on 10/22/2015, doc that there was not a	veen 9:00 AM and 12:30 PM cumentation review revealed a single plan for the out of fire sprinkler system.			Revised Date: FIRE SPRINKLER SYSTEM  I. POLICY  It is the policy of St Luke's Luthera Center to ensure that residents, sta		E:
1.00		This deficient pract Facility Maintenanc discovery.	ice was confirmed by the ee Director (JG) at the time of			visitors are protected and that a sa environment is maintained during p in which the building fire sprinkler s is out of service, for more than 4 h	ife periods system	o o

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245372 B. WING 10/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 Continued From page 3 a 24 hour period. II. PURPOSE To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire sprinkler at St Luke's Lutheran Care Center is out of service. III. RESPONSIBILITY Responsibility for development and implementation of this policy rests with the facility safety officer. IV. PROCEDURE A. Notifications 1. Upon finding that a required fire protection system is out of service: a. The following persons will be notified immediately: Facility Administrator Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 Head of Maintenance \* John Gieser -(H) 507-526-5436 (C) 507525-5818 iii. Local fire chief or fire marshal \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 \* Mike

CENTE	49 LOK MEDICALE	: & MEDICAID SERVICES					0930-033
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		245372	B. WING			10/2	2/2015
NAME OF	PROVIDER OR SUPPLIER	!	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	ES LUTHERAN CARE	CENTER			LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154	Continued From pa	age 4	K	1154	Blumenschein –Alt- 507-526-3252 iv. The facility's insurance carrier  * Chubbs # 3590-09-37 WCE 15 Mountain's Road, Warren, NJ 07059 v. The facility's monitoring company  * WH Resp Dispatch Center ACCT# 2910 800-858-7811 b. The facility operator make an immediate announcement the building PA system notifying state the nature and extent of the impairrand, in cases where the building's fisprinkler system is out of service, directing them to: i. Close all smok fire doors in the area(s) affected by impairment; and ii. Unlock all lock doors in the area(s) affected by the impairment to allow for immediate of in case of emergency. Residents we could pose a danger to themselves or others due to eloper must be closely monitored to ensurt they are accounted for at all times. 2. If the building fire sprinkler systout of service for more than 4 hours 24-hour period, Deputy State Fire Marry Gannon shall be notified by period, 1769-7779 e-mail: Larry.Gannon@state.mn.u.  B. Preplanned impairments	onse or will t over off of ment fire de and the ed exit egress who ment te that tem is s in a Marshal hone	20 A

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CENTI	ERS FOR MEDICARE	E & MEDICAID SERVICES				IVID IVO.	0930-0391
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		245372	B. WING			10/2	2/2015
NAME O	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUK	ES LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 15	4 Continued From page 2	age 5	К	154	scheduled work or testing), all the identified above will be notified, in advance, of the extent and expect duration of the impairment. In add person performing the work will be expected to place tags (as appropeach fire department connection, system control valve, fire alarm counit and/or fire alarm annunciator indicating that the system, or part has been removed from service.  C. Alternate fire alarm signal  Upon notification that the building sprinkler system is out of service, immediately implement the followiprocedure, should a fire occur dur	ed ition, the riate) at sprinkler ntrol thereof, fire staff will ng	- 1 H
					impairment:  a. The staff person discovering the fire must shout the phrase CODE RED and go the aid person(s) in immediate danger.  b. Personnel hearing code phrase announced will immediate the radio provided at each nurstation to alert all other building of and then proceed to execute their as assigned in the fire safety plan.  D. Fire watch  At the direction of the fire chief, far administrator or facility safety offic watch will be implemented.  1. Fire watch duties will be performation facility maintenance staff who have specially trained in identifying and controlling fire hazards, detecting	e code d of any g the ediately rse ccupants duties cility eer, a fire rmed by e been	

С	ENTER	RS FOR MEDICARE	& MEDICAID SERVICES				VID NO.	0930-0391
STA	TEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
			245372	B. WING	·	<del>_</del>	10/2	2/2015
1		ROVIDER OR SUPPLIER	CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  219 SOUTH RAMSEY  BLUE EARTH, MN 56013		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE	(X5) COMPLETION DATE
	K 154	Continued From pa	age 6	K	154	signs of unwanted fire, the use of processing fire extinguishers, and in occupant fire department notification techniq Evidence of such training will be maintained in each employee's perfile.  2. Fire watch personnel will:  a. Have no other dut assigned to them while the affecter protection system is out of service.  b. Carry a cell phone them to use for notification of the fidepartment.  c. Perform continuous such that each portion of the building affected by the impairment is chechnot less than 30-minute intervals. It addition to watching for and prompreporting any incidents of fire, visits smoke or strong smell of smoke or unwanted odors, the fire watch will ensure while on tour that:  Portable fire extinguishers are place, unobstructed and in proper operating condition;  Corridors and exits are free and fistorage and all other obstruction.  Exit and stairwell doors are clearly operational;  EXIT signs are visible and provilluminated;  Fire doors, smoke barrier door hazardous area doors are kept cloud latched (i.e. not tied, wedged or bloopen in any fashion);  Oxygen cylinders/containers in use are properly stored;  Electrical hazards are promptil reported and remedied;	and ues.  rsonnel  ies d fire with re us tours ng ked at n ttly ble r other also in d clear as; ear and perly rs and sed and ocked ot in	

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CENTER	(S FOR MEDICARI	E & MEDICAID SERVICES				WID NO.	0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		245372	B. WING			10/2	2/2015
	ROVIDER OR SUPPLIER		•	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154	Continued From p	age 7	К	154	No smoking or work involving or welding or the use of flammable/combustible liquids is to place (unless such work has been preauthorized and is taking place i area that is properly fire separated the remainder of the facility); and Trash and other unnecessary accumulations of combustibles are promptly removed from the buildin d. Document their tours in a Any problems found during the fire will also be documented and report the head of maintenance for immedorrection.  3. The fire watch will remplace until the impaired system has restored to normal working order a watch personnel are relieved of the duties by the fire chief, facility administrator or facility safety office.  E. Evacuation  The nature and extent of the impacoupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacually be performed in accordance we fire safety plan and take place only direction of the fire chief, facility administrator or facility safety office.	n an from  g log. watch ted to diate nain in s been and fire eir er.  irment, he uations with the y at the	
					F. System(s) restored to service  When the impaired syster been restored to normal working of a. The following personal was a service.	order:	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 10/22/2015 245372 **B WING** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 K 154 Continued From page 8 be notified immediately: Facility Administrator \* Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 Head of Maintenance ii. \* John Gieser -(H) 507-526-5436 (C) 507-525-5818 iii. Local fire chief or fire marshal \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 \* Mike Blumenschein -Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company \* Wright Hennepin Response Dispatch Center - ACCT # 2910 800-858-7811 b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service. Deputy State Fire Marshal

Event ID: 07W221

Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling:

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(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 Continued From page 9 (651) 769-7779 e-mail: Larry.Gannon@state.mn.us d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed. 10/22/15 K 155 K 155 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period. the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: St Luke's Lutheran Care Center Based on documentation review and staff interview, where a required fire alarm system is out of service for more than 4 hours in a 24-hour POLICY TITLE: FIRE PROTECTION period, the authority having jurisdiction is notified, SYSTEMS OUT OF SERVICE and the building is evacuated or an approved fire Page 1 of 3 watch is provided for all parties left unprotected by the shutdown until the fire alarm system has APPROVED BY: Margaret Brandt been returned to service. 9.6.1.8 Effective Date: 10/22/15 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed Revised Date: FIRE ALARM SYSTEM that there was not a single plan for the out of service plan for the fire alarm system.

(X2) MULTIPLE CONSTRUCTION

Facility ID: 00116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  10/22/2  STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				VID 14O.	0930-0391
NAME OF PROVIDER OR SUPPLIER  ST LUKES LUTHERAN CARE CENTER    C(XA)   D   PREFIX TAG	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	' '				
ST LUKES LUTHERAN CARE CENTER    1219 SOUTH RAMSEY BLUE EARTH, MN 56013			245372	B. WING			10/2	2/2015
CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY			CENTER		1:	219 SOUTH RAMSEY		
This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.  It is the policy of St Luke's Lutheran Care Center to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system is out of service, for more than 4 hours in a 24 hour period.  II. PURPOSE  To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire alarm at St Luke's Lutheran Care	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
III. RESPONSIBILITY  Responsibility for development and implementation of this policy rests with the facility safety officer.  IV. PROCEDURE  A. Notifications  1. Upon finding that a required fire protection system is out of service: a. The following persons will		This deficient prac	tice was confirmed by the	K	155	It is the policy of St Luke's Luthera Center to ensure that residents, stavisitors are protected and that a savisitors are protection fire alarm system to service, for more than 4 hours 24 hour period.  II. PURPOSE  To outline interim fire/life safety mentate that will be implemented during petime, preplanned or otherwise, in with the fire alarm at St Luke's Luthera Center is out of service.  III. RESPONSIBILITY  Responsibility for development and implementation of this policy rests facility safety officer.  IV. PROCEDURE  A. Notifications  1. Upon finding that a refire protection system is out of services.	aff and afe beriods tem is ars in a  easures riods of which n Care  d with the  quired vice:	

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245372 B. WING 10/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 11 Brandt (W) 507-526-2184 (C) 515-320-0443 ii. Head of Maintenance \* John Gieser -(H) 507-526-5436 (C) 507525-5818 iii. Local fire chief or fire marshal \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 \* Mike Blumenschein - Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company WH Response Dispatch Center ACCT# 2910 800-858-7811 b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire alarm system is out of service, directing them to: Close all smoke and fire doors in the area(s) affected by the impairment; and ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to

(X2) MULTIPLE CONSTRUCTION

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 10/22/2015 B. WING 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 | Continued From page 12 themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times. 2. If the building fire alarm system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone (651) 769-7779 Email: Larry.Gannon@state.mn.us B. Preplanned impairments For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service. C. Alternate fire alarm signal Upon notification that the building fire alarm system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment: a. The staff person discovering the fire must shout the code phrase CODE RED and go the aid of any person(s) in immediate danger. b. Personnel hearing the

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING (	01 - MAIN BUILDING 01	COMP	PLETED
		245372	B. WING	_		10/2	2/2015
NAME OF P	ROVIDER OR SUPPLIER	- <del> </del>			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY SLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
The Address	Continued From p		K	155	code phrase announced will immer use the radio provided at each nustation to alert all other building or and then proceed to execute their as assigned in the fire safety plan.  D. Fire watch  At the direction of the fire chief, far administrator or facility safety office watch will be implemented.  1. Fire watch duties will be performed facility maintenance staff who have specially trained in identifying and controlling fire hazards, detecting signs of unwanted fire, the use of fire extinguishers, and in occupant fire department notification technic Evidence of such training will be maintained in each employee's perfile.  2. Fire watch personnel a. Have no other duting assigned to them while the affect protection system is out of service b. Carry a cell phone them to use for notification of the department.  c. Perform continuous such that each portion of the build affected by the impairment is chent less than 30-minute intervals.	coupants duties coupants duties coupants duties coupants	
					addition to watching for and prom reporting any incidents of fire, vis smoke or strong smell of smoke unwanted odors, the fire watch wensure while on tour that:	ptly ible or other	
					Portable fire extinguishers are place, unobstructed and in properties.  If continue to the continue to th	r	Page 14 of

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 14 operating condition; Corridors and exits are free and clear of storage and all other obstructions; Exit and stairwell doors are clear and fully operational; EXIT signs are visible and properly illuminated; Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked open in any fashion); Oxygen cylinders/containers not in use are properly stored; Electrical hazards are promptly reported and remedied; No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and Trash and other unnecessary accumulations of combustibles are promptly removed from the building. d. Document their tours in a log. Any problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction. 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer.

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) DATE SURVEY

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(X2) MULTIPLE CONSTRUCTION

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245372	B. WING	3		10/2	22/2015
	PROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC	·ΙΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 155	Continued From pa	age 16	K	155	* Wright He Response Dispatch Center - ACC 2910  800-858- b. The facility operate make an announcement over the k PA system notifying staff that the s has been restored, smoke and fire can be reopened, exit door securit restored and they can return to the regular routine.  c. If notified that the fire alarm and/or fire sprinkler syst out of service, Deputy State Fire N Larry Gannon shall be informed th impaired system has been restore normal working order by calling: (651) 769-7779 Email: Larry Gannon@state.mn.us d. Any tags placed on fire department connections, fire sprin system control valves, fire alarm c units and/or fire alarm annunciator will be promptly removed.	-7811 or will ouilding ystem doors y ir building em was larshal at the d to	

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PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2

(X3) DATE SURVEY COMPLETED

245372

B. WING

10/22/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1219 SOUTH RAMSEY

ST LUKE	S LUTHERAN CARE CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013	
(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
K 000	INITIAL COMMENTS	K 00	00	
	FIRE SAFETY			
	THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.			
	UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.			
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State			

Fire Marshal Division. At the time of this survey, St. Lukes Lutheran Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** 

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/13/2015

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

Facility ID: 00116

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 2 B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE **FOLLOWING INFORMATION:** 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of St. Luke's Lutheran Care Center consists of the 2005 building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 89 at time of the survey. 10/22/15 NFPA 101 LIFE SAFETY CODE STANDARD K 154 K 154 SS=D Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left

STATEMENT	T OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2		(X3) DATE SURVEY COMPLETED				
		245372	B. WING			10/2	2/2015
	PROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154	Continued From pa unprotected by the system has been re	shutdown until the sprinkler	Κ.	154			
	Based on docume interview, where a system is out of se a 24-hour period, t is notified, and the approved fire watc parties left unprote sprinkler system has 9.7.6.1  On facility tour bet on 10/22/2015, document there was not	is not met as evidenced by: Intation review and staff required automatic sprinkler rvice for more than 4 hours in the authority having jurisdiction building is evacuated or an the system is provided for all cted by the shutdown until the tas been returned to service.  In the system is provided for all cted by the shutdown until the tas been returned to service.  In the system is provided for all cted by the shutdown until the tas been returned to service.	TV .		St Luke's Lutheran Care Center  POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE Page 1 of 3  APPROVED BY: Margaret Brandt Effective Date: 10/22/15  Revised Date: FIRE SPRINKLER SYSTEM	ON	
	This deficient prac	tice was confirmed by the ce Director (JG) at the time of			It is the policy of St Luke's Luthera Center to ensure that residents, st visitors are protected and that a sa environment is maintained during in which the building fire sprinkler is out of service, for more than 4 h a 24 hour period.  II. PURPOSE  To outline interim fire/life safety me that will be implemented during petime, preplanned or otherwise, in withe fire sprinkler at St Luke's Lutheral Center (1) and the service of the service (1) and the service (1) are the service (1)	aff and afe periods system ours in easures criods of	

		& MEDICAID SERVICES	T (VO) MILII	TIDI		(X3) DATE	SURVEY
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION 02 - BUILDING 2	COMPLETED	
		245372	B. WING			10/2	22/2015
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY		
ST LUKE	S LUTHERAN CARE	CENTER		1	BLUE EARTH, MN 56013		
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K 154	Continued From pa	age 3	К	154	Care Center is out of service.		
					III. RESPONSIBILITY		
					Responsibility for development an implementation of this policy rests facility safety officer.	d with the	B 81
					IV. PROCEDURE		111
	54				A. Notifications		
ĸ					1. Upon finding that a refire protection system is out of ser a. The following per be notified immediately:  i. Facility Admir  * Margare Brandt (W) 507-526-2184 (C) 515-320-0443	vice: sons will nistrator	1 E
					ii. Head of Mair * John Gie (H) 507-526-5436 (C) 507525-58 iii. Local fire chi	eser – 118	
					marshal * Roger D Chief – (C) 507-525-0851 (W) 507-526-2191 * Mike	avis –	
					Blumenschein –Alt- 507-526-325 iv. The facility's insurance carrier	2	
					* Chubbs # 3590-09-37 WCE 15 Mountai Road, Warren, NJ 07059 v. The facility's		
					monitoring company		

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(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 2 B WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 Continued From page 4 \* WH Response Dispatch Center ACCT# 2910 800-858-7811 The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire sprinkler system is out of service. directing them to: Close all smoke and fire doors in the area(s) affected by the impairment; and Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times. 2. If the building fire sprinkler system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone (651) 769-7779 e-mail: Larry.Gannon@state.mn.us B. Preplanned impairments For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 2 10/22/2015 B. WING 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 154 K 154 Continued From page 5 unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service. C. Alternate fire alarm signal Upon notification that the building fire sprinkler system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment: a. The staff person discovering the fire must shout the code phrase CODE RED and go the aid of any person(s) in immediate danger. b. Personnel hearing the code phrase announced will immediately use the radio provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan. D. Fire watch At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented. 1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee's personnel file. Fire watch personnel will: a. Have no other duties

CENTERS FOR MEDICARE & MEDICAID SERVICES			OND 140. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG <b>02 - BUILDING 2</b>	(X3) DATE SURVEY COMPLETED
245372	B. WING		10/22/2015
NAME OF PROVIDER OR SUPPLIER  ST LUKES LUTHERAN CARE CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	
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K 154 Continued From page 6	K 1	DEFICIENCY)	ted fire ce. ne with e fire ous tours Iding ecked at i. In inptly sible or other vill also re in er and clear ons; clear and roperly pors and closed and blocked is not in otly ing cutting is taking en

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			245372	B. WING			10/2	22/2015
		ROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
0.00	K 154	Continued From pa	age 7	К	154	accumulations of combustibles are promptly removed from the buildin d. Document their tours in a Any problems found during the fire will also be documented and report the head of maintenance for immercorrection.  3. The fire watch will remplace until the impaired system has restored to normal working order a watch personnel are relieved of the duties by the fire chief, facility administrator or facility safety office.  E. Evacuation  The nature and extent of the impactoupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evac will be performed in accordance we fire safety plan and take place onlidirection of the fire chief, facility administrator or facility safety office.  F. System(s) restored to service	g. log. e watch rted to ediate nain in as been and fire eir er.  irment, ne uations vith the y at the	
						When the impaired system been restored to normal working of a. The following per be notified immediately:  i. Facility Adminity * Margare Brandt (W) 507-526-2184 (C) 515-320-0443	m has order: sons will nistrator et	
						* John Gie (H) 507-526-5436 (C) 507-525-56	ser –	

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 2 10/22/2015 B. WING 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 K 154 Continued From page 8 iii. Local fire chief or fire marshal \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 \* Mike Blumenschein -Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. 'The facility's monitoring company \* Wright Hennepin Response Dispatch Center - ACCT# 2910 800-858-7811 b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: (651) 769-7779 e-mail: Larry.Gannon@state.mn.us d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V /	LTIPLE CONSTRUCTION DING <b>02 - BUILDING 2</b>		E SURVEY PLETED
		245372	B. WING			22/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	ODE:	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
K 154	Continued From p	page 9	K	154		
K 155 SS=D	Where a required service for more the authority having building is evacual provided for all page 1.00 per service of the servi	AFETY CODE STANDARD  fire alarm system is out of than 4 hours in a 24-hour period, and jurisdiction is notified, and the ated or an approved fire watch is arties left unprotected by the efire alarm system has been e. 9.6.1.8	K	155	9 18 = 3	10/22/15
	Based on documinterview, where a out of service for period, the author and the building is watch is provided by the shutdown been returned to  On facility tour be on 10/22/2015, do that there was no	is not met as evidenced by: sentation review and staff a required fire alarm system is more than 4 hours in a 24-hour rity having jurisdiction is notified, s evacuated or an approved fire for all parties left unprotected until the fire alarm system has service. 9.6.1.8  Etween 9:00 AM and 12:30 PM occumentation review revealed t a single plan for the out of the fire alarm system.		St Luke's Lutheran Care C POLICY TITLE: FIRE PRO SYSTEMS OUT OF SERV Page 1 of 3  APPROVED BY:Margaret Effective Date: 10/22/1  Revised Date: FIRE ALARM SYSTEM	DTECTION ICE Brandt	
	This deficient pra Facility Maintenar discovery.	ctice was confirmed by the nce Director (JG) at the time of		I. POLICY  It is the policy of St Luke's Center to ensure that residuistions are protected and environment is maintained in which the building fire a out of service, for more that	lents, staff and that a safe during periods larm system is	

	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				1	0936-0391
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 02 - BUILDING 2	(X3) DATE	SURVEY PLETED
			245372	B. WING			10/2	2/2015
ł	NAME OF F	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		=
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	K 155	Continued From pa	age 10	К	155	24 hour period.		
						II. PURPOSE		
			×			To outline interim fire/life safety me that will be implemented during pe time, preplanned or otherwise, in the fire alarm at St Luke's Luthera Center is out of service.	riods of which	
						III. RESPONSIBILITY		T IN
						Responsibility for development an implementation of this policy rests facility safety officer.	d with the	
						3) .t		
						IV. PROCEDURE		
						A. Notifications		
						Upon finding that a refire protection system is out of ser a. The following per be notified immediately:     i. Facility Admir     * Margare*	vice: sons will nistrator	
						Brandt (W) 507-526-2184 (C) 515-320-0443 ii. Head of Mair	itenance	
						* John Gie (H) 507-526-5436 (C) 507525-58 iii. Local fire chie	18	
						marshal * Roger D Chief – (C) 507-525-0851 (W) 507-526-2191	avis –	

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - BUILDING 2 10/22/2015 245372 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 11 \* Mike Blumenschein - Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company \* WH Response Dispatch Center ACCT# 2910 800-858-7811 b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire alarm system is out of service, directing them to: Close all smoke and fire doors in the area(s) affected by the impairment; and ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times. 2. If the building fire alarm system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone (651) 769-7779

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING 2	(X3) DATE COMF	SURVEY
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	PROVIDER OR SUPPLIER	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013	**	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 155	Continued From pa	age 12	- K	155	Email: Larry.Gannon@state.mn.us  B. Preplanned impairments (e.g. scheduled work or testing), all the identified above will be notified, in advance, of the extent and expect duration of the impairment. In addiperson performing the work will be expected to place tags (as appropeach fire department connection, system control valve, fire alarm counit and/or fire alarm annunciator indicating that the system, or part has been removed from service.  C. Alternate fire alarm signal  Upon notification that the building alarm system is out of service, staimmediately implement the followiprocedure, should a fire occur durimpairment:  a. The staff person discovering the fire must shout the phrase CODE RED and go the aid person(s) in immediate danger.  b. Personnel hearing code phrase announced will immediate the radio provided at each nuistation to alert all other building or and then proceed to execute their as assigned in the fire safety plan.  D. Fire watch  At the direction of the fire chief, far administrator or facility safety office.	parties ed tion, the riate) at sprinkler ntrol thereof,  fire ff will ng ing the e code d of any g the ediately rse ccupants duties  cility	

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 2 B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 13 watch will be implemented. 1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee's personnel file. 2. Fire watch personnel will: a. Have no other duties assigned to them while the affected fire protection system is out of service. b. Carry a cell phone with them to use for notification of the fire department. c. Perform continuous tours such that each portion of the building affected by the impairment is checked at not less than 30-minute intervals. In addition to watching for and promptly reporting any incidents of fire, visible smoke or strong smell of smoke or other unwanted odors, the fire watch will also ensure while on tour that: Portable fire extinguishers are in place, unobstructed and in proper operating condition: Corridors and exits are free and clear of storage and all other obstructions; Exit and stairwell doors are clear and fully operational; EXIT signs are visible and properly illuminated: Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked

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(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - BUILDING 2 B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 14 open in any fashion); Oxygen cylinders/containers not in use are properly stored; Electrical hazards are promptly reported and remedied; No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and Trash and other unnecessary accumulations of combustibles are promptly removed from the building. d. Document their tours in a log. Any problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer. E. Evacuation The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility

CENTERS FOR	<b>MEDICARE</b>	& MEDICAID SERVICES				WIB NO.	0936-0391
STATEMENT OF DEFIC AND PLAN OF CORREC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D2 - BUILDING 2	(X3) DATE COMF	SURVEY
		245372	B. WING			10/2	2/2015
NAME OF PROVIDER	OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKES LUTH		CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX (EA TAG REG	CH DEFICIENC'	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 155 Continu			K	155	administrator or facility safety office  F. System(s) restored to service  When the impaired system been restored to normal working of a. The following personal be notified immediately:  i. Facility Admin  * Margare  Brandt (W) 507-526-2184 (C) 515-320-0443  ii. Head of Main  * John Gies  (H) 507-526-5436 (C) 507-525-58  iii. Local fire chies  marshal  * Roger D  Chief – (C) 507-525-0851 (W) 507-526-2191  * Mike  Blumenschein –Alt- 507-526-325  iv. The facility's insurance carrier  * Chubbs  # 3590-09-37 WCE 15 Mountain Road, Warren, NJ 07059  v. The facility's monitoring company  * Wright H  Response Dispatch Center - AC 2910  800-858  b. The facility opera make an announcement over the PA system notifying staff that the shas been restored, smoke and fire can be reopened, exit door security restored and they can return to the state of the part o	n has order: sons will histrator et tenance ser – 318 ef or fire avis –  2 policy view ennepin CT # 3-7811 tor will building system e doors ty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X2) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X3) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X4) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X5) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X6) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X7) PROVIDER/SUPPLIER/SUPPLIER/ IDENTIFICATION NUMBER  (X7) PROVIDER/SUPPLIER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BUILDING 2	(X3) DATE SURVEY COMPLETED		
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ST LUKE	STREET ADDRESS, CITY, STATE, ZIP CODE  1219 SOUTH RAMSEY  BLUE EARTH, MN 56013  A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			(X5)				
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K 155	2000000		K	1155	regular routine.  c. If notified that the fire alarm and/or fire sprinkler syste out of service, Deputy State Fire M Larry Gannon shall be informed the impaired system has been restored normal working order by calling:  (651) 769-7779  Email: Larry Gannon@state.mn.us  d. Any tags placed on fire department connections, fire spring system control valves, fire alarm counits and/or fire alarm annunciator will be promptly removed.	em was larshal at the d to		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X4) ID

PRÉFIX

TAG

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 ADDITION (X3) DATE SURVEY COMPLETED

245372

B. WING

ID

**PREFIX** 

10/22/2015

NAME OF PROVIDER OR SUPPLIER

ST LUKES LUTHERAN CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1219 SOUTH RAMSEY BLUE EARTH, MN 56013

REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**)

K 000 INITIAL COMMENTS

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Lukes Lutheran Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** 

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or

K 000

**EPOC** 

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

11/13/2015

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

Facility ID: 00116

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION 10/22/2015 245372 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER **BLUE EARTH, MN 56013** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE **FOLLOWING INFORMATION:** 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 03 of St. Luke's Lutheran Care Center consists of the 2008 mechanical building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 89 at time of the survey. 10/22/15 NFPA 101 LIFE SAFETY CODE STANDARD K 154 K 154 SS=D Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire

(X2) MULTIPLE CONSTRUCTION

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 K 154 | Continued From page 2 watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. This STANDARD is not met as evidenced by: St Luke's Lutheran Care Center Based on documentation review and staff interview, where a required automatic sprinkler system is out of service for more than 4 hours in POLICY TITLE: FIRE PROTECTION a 24-hour period, the authority having jurisdiction SYSTEMS OUT OF SERVICE is notified, and the building is evacuated or an approved fire watch system is provided for all Page 1 of 3 parties left unprotected by the shutdown until the APPROVED BY: Margaret Brandt sprinkler system has been returned to service. Effective Date: 10/22/15 9.7.6.1 Revised Date: FIRE SPRINKLER SYSTEM On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed **POLICY** that there was not a single plan for the out of service plan for the fire sprinkler system. It is the policy of St Luke's Lutheran Care Center to ensure that residents, staff and visitors are protected and that a safe This deficient practice was confirmed by the environment is maintained during periods Facility Maintenance Director (JG) at the time of in which the building fire sprinkler system discovery. is out of service, for more than 4 hours in a 24 hour period. II. PURPOSE To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire sprinkler at St Luke's Lutheran Care Center is out of service.

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1 7	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING 03 - 2008 ADDITION			(X3) DATE SURVEY COMPLETED	
			245372	B. WING		-	10/2	22/2015	
		PROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013			
-	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION E PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE			
	K 154	Continued From pa	age 3	K	154	III. RESPONSIBILITY  Responsibility for development and implementation of this policy rests facility safety officer.  IV. PROCEDURE  A. Notifications  1. Upon finding that a reffire protection system is out of sema. The following persibe notified immediately:  i. Facility Admin  * Margare  Brandt (W) 507-526-2184 (C) 515-320-0443  ii. Head of Maint  * John Gies (H) 507-526-5436 (C) 507525-58*  iii. Local fire chiese marshal  * Roger Date Chief — (C) 507-525-0851 (W) 507-526-2191  * Mike  Blumenschein —Alt- 507-526-3252  iv. The facility's	quired vice: sons will istrator of tenance ser – 18 or fire avis –		
						insurance carrier  * Chubbs  # 3590-09-37 WCE 15 Mountain Road, Warren, NJ 07059  v. The facility's monitoring company  * WH Res Dispatch Center ACCT# 2910	i View		

STATEMENT	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 ADDITION			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/2	2/2015	
	PROVIDER OR SUPPLIER	CENTER	,	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 154	Continued From pa	age 4	K	1154	b. The facility operate make an immediate announcement the building PA system notifying state the nature and extent of the impair and, in cases where the building's sprinkler system is out of service, directing them to:  i. Close all smooth fire doors in the area(s) affected by impairment; and  ii. Unlock all lock doors in the area(s) affected by the impairment to allow for immediate in case of emergency. Residents we could pose a danger to themselves or others due to elope must be closely monitored to ensure they are accounted for at all times.  2. If the building fire sprinkler system of service for more than 4 hour 24-hour period, Deputy State Fire Larry Gannon shall be notified by (651) 769-7779 e-mail: Larry.Gannon@state.mn.th.  B. Preplanned impairments  For preplanned impairments  For preplanned impairments  For preplanned impairments  for preplanned impairments. In add person performing the work will be expected to place tags (as apprope ach fire department connection, system control valve, fire alarm counit and/or fire alarm annunciator indicating that the system, or part	at over aff of ment fire ke and y the ked exit e egress who ment re that stem is rs in a Marshal phone us parties ed ition, the eriate) at sprinkler introl		

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION 245372 B. WING 10/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 K 154 | Continued From page 5 has been removed from service. C. Alternate fire alarm signal Upon notification that the building fire sprinkler system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment: a. The staff person discovering the fire must shout the code phrase CODE RED and go the aid of any person(s) in immediate danger. b. Personnel hearing the code phrase announced will immediately use the radio provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan. D. Fire watch At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented. 1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee's personnel file. 2 Fire watch personnel will: a. Have no other duties assigned to them while the affected fire protection system is out of service.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				VID NO.	0936-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - 2008 ADDITION	(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/2	2/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LUKES LUTHERAN CARE CENTER			1:	219 SOUTH RAMSEY		
STLUK	ES LUTHERAN CARE	CENTER		В	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
K 154	Continued From page 2	age 6	K	154	b. Carry a cell phone them to use for notification of the fidepartment.  c. Perform continuous such that each portion of the building affected by the impairment is chech not less than 30-minute intervals. It addition to watching for and prompreporting any incidents of fire, visit smoke or strong smell of smoke of unwanted odors, the fire watch will ensure while on tour that:  Portable fire extinguishers are place, unobstructed and in proper operating condition;  Corridors and exits are free and fixed stainwell doors are clearly operational;  Exit and stainwell doors are clearly operational;  EXIT signs are visible and problem in any fashion);  Oxygen cylinders/containers reuse are properly stored;  Electrical hazards are prompting or welding or the use of flammable/combustible liquids is the place (unless such work has been preauthorized and is taking place area that is properly fire separated the remainder of the facility); and  Trash and other unnecessary accumulations of combustibles are promptly removed from the building or the buildi	ire us tours ing ked at in bitly ble r other i also in d clear ns; ear and perly rs and psed and ocked not in y cutting aking in an if from	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 ADDITION			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/2	2/2015	
NAME OF	PROVIDER OR SUPPLIER	J.		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	O LUTUEDAN CADE	CENTER		1:	219 SOUTH RAMSEY			
SILUKI	ES LUTHERAN CARE	CENTER		В	BLUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 154	Continued From pa	age 7	K	154	d. Document their tours in a Any problems found during the fire will also be documented and repor the head of maintenance for imme correction.  3. The fire watch will rem place until the impaired system ha restored to normal working order a watch personnel are relieved of the duties by the fire chief, facility administrator or facility safety office E. Evacuation  The nature and extent of the impa coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evace will be performed in accordance we fire safety plan and take place only direction of the fire chief, facility administrator or facility safety office  F. System(s) restored to service  When the impaired system been restored to normal working of a. The following pers be notified immediately: i. Facility Admin * Margare Brandt (W) 507-526-2184 (C) 515-320-0443  ii. Head of Main * John Gie (H) 507-526-5436 (C) 507-525-58 iii. Local fire chief marshal	e watch ted to ted ted to ted		

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 154 Continued From page 8 \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 \* Mike Blumenschein -Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company \* Wright Hennepin Response Dispatch Center - ACCT# 2910 800-858-7811 b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: (651) 769-7779 e-mail: Larry.Gannon@state.mn.us d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0000-0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 3 - 2008 ADDITION		E SURVEY PLETED
		245372	B. WING			10/3	22/2015
	PROVIDER OR SUPPLIER	CENTER		12	REET ADDRESS, CITY, STATE, ZIP CODE 119 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 155 SS=D	Where a required the service for more that the authority having building is evacuated provided for all particular shutdown until the returned to service.  This STANDARD Based on docume interview, where a out of service for not period, the authoritiand the building is watch is provided to by the shutdown unbeen returned to some control of the shutdown unbeen return	is not met as evidenced by: entation review and staff required fire alarm system is nore than 4 hours in a 24-hour ty having jurisdiction is notified, evacuated or an approved fire for all parties left unprotected ntil the fire alarm system has	K *	155	St Luke's Lutheran Care Center  POLICY TITLE: FIRE PROTECTION SYSTEMS OUT OF SERVICE Page 1 of 3  APPROVED BY:Margaret Brandt Effective Date: 10/22/15  Revised Date: FIRE ALARM SYSTEM  I. POLICY  It is the policy of St Luke's Lutheral Center to ensure that residents, st visitors are protected and that a safe environment is maintained during in which the building fire alarm systems out of service, for more than 4 hours.	n Care aff and afe periods tem is	10/22/15
					24 hour period.  II. PURPOSE		

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				-	0936-0391	
STATEMENT AND PLAN C	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 ADDITION			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/2	2/2015	
NAME OF F	PROVIDER OR SUPPLIER		T	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				12	219 SOUTH RAMSEY			
ST LUKE	S LUTHERAN CARE	CENTER		В	LUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 155	Continued From pa	age 10	K 1	55				
					To outline interim fire/life safety me that will be implemented during pe time, preplanned or otherwise, in the fire alarm at St Luke's Luthera Center is out of service.	riods of which		
					III. RESPONSIBILITY  Responsibility for development an implementation of this policy rests facility safety officer.	d with the	2 2 1 X I	
					lacinty surety officer.			
					IV. PROCEDURE			
					A. Notifications			
	8				Upon finding that a refire protection system is out of ser     a. The following per be notified immediately:     i. Facility Admir	vice: sons will		
					* Margare Brandt (W) 507-526-2184 (C) 515-320-0443 ii. Head of Main	et		
			*		* John Gie (H) 507-526-5436 (C) 507525-58 iii. Local fire chie	ser – 18		
					marshal * Roger D Chief – (C) 507-525-0851 (W) 507-526-2191	avis –		
					* Mike Blumenschein –Alt- 507-526-325 iv. The facility's insurance carrier	2		
				_	ecility ID: 00116 If continue	ation about	Page 11 of 1	

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(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING 03 - 2008 ADDITION AND PLAN OF CORRECTION 10/22/2015 245372 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 Continued From page 11 \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company \* WH Response Dispatch Center ACCT# 2910 800-858-7811 b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building's fire alarm system is out of service, directing them to: Close all smoke and fire doors in the area(s) affected by the impairment; and ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times. 2. If the building fire alarm system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone (651) 769-7779 Email: Larry.Gannon@state.mn.us B. Preplanned impairments

(X2) MULTIPLE CONSTRUCTION

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

	CENTER	O LOK MEDICAKE	& MEDICAID SERVICES				1	0330-0331
	STATEMENT	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION 03 - 2008 ADDITION	(X3) DATE SURVEY COMPLETED	
			245372	B. WING		<del></del>	10/2	22/2015
	NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICLE (CORRECTION CORRECTION)	O BE	(X5) COMPLETION DATE
Co. Annabation, Co.	K 155	Continued From pa	age 12	К	155	For preplanned impairments (e.g. scheduled work or testing), all the identified above will be notified, in advance, of the extent and expect duration of the impairment. In add person performing the work will be expected to place tags (as appropeach fire department connection, system control valve, fire alarm counit and/or fire alarm annunciator indicating that the system, or part has been removed from service.  C. Alternate fire alarm signal  Upon notification that the building alarm system is out of service, staimmediately implement the following procedure, should a fire occur during impairment:  a. The staff person discovering the fire must shout the phrase CODE RED and go the aid person(s) in immediate danger.  b. Personnel hearing code phrase announced will immediate the radio provided at each nustation to alert all other building of and then proceed to execute their as assigned in the fire safety plan.  D. Fire watch  At the direction of the fire chief, far administrator or facility safety office watch will be implemented.  1. Fire watch duties will be performanced in identifying and specially trained in identifying and specially train	ed ition, the edition, the edition, the edition, the edition in th	

Facility ID: 00116

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - 2008 ADDITION	(X3) DATE SURVEY COMPLETED		
		245372	B. WING			10/2	2/2015	
	ROVIDER OR SUPPLIER	CENTER		121	EET ADDRESS, CITY, STATE, ZIP CODE 9 SOUTH RAMSEY UE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	, ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
K 155	Continued From pa	ige 13	K1		controlling fire hazards, detecting esigns of unwanted fire, the use of pfire extinguishers, and in occupant fire department notification techniq Evidence of such training will be maintained in each employee's perfile.  2. Fire watch personnel va. Have no other duti assigned to them while the affected protection system is out of service.  b. Carry a cell phone them to use for notification of the fidepartment.  c. Perform continuous such that each portion of the building affected by the impairment is chechnot less than 30-minute intervals. I addition to watching for and prompreporting any incidents of fire, visib smoke or strong smell of smoke or unwanted odors, the fire watch will ensure while on tour that:  Portable fire extinguishers are place, unobstructed and in proper operating condition;  Corridors and exits are free an of storage and all other obstruction.  Exit and stairwell doors are clefully operational;  EXIT signs are visible and profilluminated;  Fire doors, smoke barrier door hazardous area doors are kept clolatohed (i.e. not tied, wedged or bloopen in any fashion);	ortable and ues. sonnel vill: es difire with re is tours ng ked at n tily ble other also in diclear is; ear and perly s and sed and ocked		
	7(02-99) Previous Versions	s Obsolete Event ID: 07W	J221	Faaili	Oxygen cylinders/containers n  ty ID: 00116	1-1	Page 14 of 17	

III X

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION 10/22/2015 B. WING 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 155 K 155 Continued From page 14 use are properly stored; Electrical hazards are promptly reported and remedied; No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and Trash and other unnecessary accumulations of combustibles are promptly removed from the building. d. Document their tours in a log. Any problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction. 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer. E. Evacuation The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility administrator or facility safety officer. F. System(s) restored to service

Event ID: 07W221

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PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 03 - 2008 ADDITION B. WING 10/22/2015 245372 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 155 K 155 | Continued From page 15 When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: **Facility Administrator** i. \* Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 Head of Maintenance \* John Gieser -(H) 507-526-5436 (C) 507-525-5818 iii. Local fire chief or fire marshal \* Roger Davis -Chief - (C) 507-525-0851 (W) 507-526-2191 Mike Blumenschein -Alt- 507-526-3252 iv. The facility's insurance carrier \* Chubbs policy # 3590-09-37 WCE 15 Mountain View Road, Warren, NJ 07059 v. The facility's monitoring company \* Wright Hennepin Response Dispatch Center - ACCT # 2910 800-858-7811 b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal

Facility ID: 00116

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 11/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - 2008 ADDITION		SURVEY PLETED	
		245372	B, WING			10/22/20		
	PROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013	P CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE				
K 155	Continued From pa	nge 16	K1	55	Larry Gannon shall be informed that impaired system has been restored normal working order by calling: (651) 769-7779  Email: Larry.Gannon@state.mn.us d. Any tags placed on fire department connections, fire sprint system control valves, fire alarm counits and/or fire alarm annunciator will be promptly removed.	d to s e kler ontrol		
						KT L JII	N U	

Event ID: 07W221