MDH
Minnesota
Department
of Health

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:

F**176 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 (l) 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.

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,

Lyla Burkman

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-308-2104 Fax: 218-308-2122

cc: 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		11/14/15

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.

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F 441	Continued From page 1 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to change gloves after contact with a wound during a dressing change for 1 of 2 residents (R13) observed for a dressing change. In addition the facility failed to clean a nebulizer machine between use for 2 of 4 residents (R6, R32) observed during medication administration observation. Findings include: R13's physician order dated 10/12/15, included daily dressing change to left and right heel wounds. On 10/21/15, at 10:20 a.m. a dressing change was completed on left and right heel wounds by licensed practical nurse (LPN)-C and registered nurse (RN)-A. The following was observed: -Left heel wound: After LPN-C removed the soiled	F 441	F441 INFECTION CONTROL On 10/21/15, Director of Nursing met with RN-A. RN-A reported that she did not change her gloves after measuring wound because she thought she had not touched the wound while measuring. RN-A stated that technically she should have changed her gloves. On 10/23/15, copies of the facility policy and procedure for glove use and the World Health Organization's "Your 5 moments for HAND HYGIENE" handout were posted in each resident care area for 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	

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	245372	A. BUILDING _____ B. WING _____	10/22/2015

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F 441	Continued From page 2 dressing RN-A put on clean gloves and measured the wound using a paper wound measuring ruler. RN-A was observed to touch wound bed and wound edges during measurement. After measurement was completed RN-A held residents left leg while LPN-C completed the treatment. RN-A was observed to touch R13's bedding, hem of residents left pant leg, and top of residents left foot with the soiled gloves. After completion of the dressing change, RN-A removed the soiled gloves, washed hands and donned clean gloves. -Right heel: After LPN-C removed the soiled dressing from R13's right heel RN-A measured the wound using a paper wound measuring ruler. RN-A was observed to touch the wound bed and wound edges during the measurement. After measurement of the wound was completed, RN-A held residents right leg while LPN-C completed the treatment. RN-A was observed to touch R13's bedding, clothing, and right leg with the soiled gloves. On 10/21/15, at 10:40 a.m. RN-A verified clean gloves had come in contact with the wounds during dressing change on both heels and that the gloves had not been changed before touching R13's bedding, clothing, and skin. On 10/22/15, at 10:29 a.m. the director of nursing (DON) stated the expectation had been that gloves were to be changed when soiled prior to touching clean items. Policy and procedure for glove use dated 6/15/15 gloves read "Gloves should always be changed between patients and between clean and contaminated sites on same patient."	F 441	revised the facility procedure for hand-held/mask nebulizer and inhaler spacer cleaning and maintenance to include rinsing in-between each use along with taking pieces apart and placing on a cloth to air dry. Per Salter Labs, nebulizer kits will continue to be soaked in antibacterial detergent and warm water for 30 minutes, rinsed and allowed to air dry 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 policy and procedure for glove use. Licensed nurses and trained medication aides will be accountable for following the facility's procedure for hand-held/mask nebulizer and inhaler spacer cleaning. All Nursing Department staff members are required to attend an in-service session that will cover the following topics: 1. Policy and procedure for glove use 2. Hand hygiene 3. Hand-Held/Mask Nebulizer and Inhaler Spacer Cleaning and Maintenance Policy and Procedure The in-service sessions will be held on 11/12/15 and 11/13/15. Staff members 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 then ongoing on a monthly basis, will randomly monitor the cleaning of nebulizer equipment to ensure compliance with	

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ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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F 441	Continued From page 3 NEBULIZER EQUIPMENT: R6's physician orders dated 9/3/15, included DuoNeb (medication used to treat spasm of the bronchi) 3 milliliter (ML) solution four times a day (QID) for emphysema. During observation of medication administration on 10/20/15, at 6:51 p.m. LPN-A entered R6's room with DuoNeb medication vial. R6's nebulizer medication cup and mouth piece were noted to be connected, hanging on the nebulizer machine. The medication cup contained liquid. LPN-A disconnected the mouthpiece, emptied the medication vial into the cup, reattached the mouth piece, started the nebulizer and handed it to the resident. LPN-A did not empty the residual liquid from the medication cup prior to pouring medication from the vial into the cup. On 10/20/15 at 6:58 p.m. LPN-A stated R6's nebulizer medication cup and mouth piece should have been emptied and dried after it was last used at 4:00 p.m. and verified the medication cup had contained liquid. LPN-A stated the facility procedure had been to disconnect the medication cup and mouth piece and set them on a cloth to dry between use, and further stated the equipment was cleaned and rinsed once daily. 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 mask covering the	F 441	facility procedure. Results will be reported to the Director of Nursing. Results of the random audit will also be included in the quarterly Infection Control Report prepared for the Quality Assessment and Assurance Committee. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 441	Continued From page 4	F 441		

nose and mouth. LPN-B removed the mask, disconnected the medication cup and mask and placed them on a cloth.

On 10/21/15, at 11:04 a.m. LPN B reported nebulizer administration equipment was not cleaned or rinsed between use and stated "but they are cleaned on evening shift."

On 10/22/15, at 10:25 a.m. the DON verified the facility procedure for nebulizer medication equipment had been to let air dry between use and cleaned and rinsed once daily. DON stated the facility follows Centers for Disease Control and Prevention (CDC) recommendation for nebulizer cleaning.

On 10/22/15, at 10:32 a.m. the consultant pharmacist reported nebulizer equipment needed to be rinsed each time it is used and stated because the residents' mouth and nose had touched those pieces there is an increased chance of bacterial growth.

Recommendations of CDC and the Healthcare Infection Control Practices guidelines dated August 2003 included between treatments on the same patient, small-volume medication nebulizers (in-line and hand-held) should be cleaned, disinfected, rinsed with sterile water (if rinsing is needed) and dried in the prevention of transmission of microorganisms. The report read, "This report updates, expands, and replaces the previously published CDC "Guideline" for Prevention of Nosocomial Pneumonia".

The facility Hand-held Nebulizer and Inhaler Spacer Cleaning and maintenance policy updated 3/2014 included "Prevention of Nosocomial

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F 441	Continued From page 5 Bacterial Pneumonia, CDC 1994."	F 441		

REVISED

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245372	A. Building B. Wing	12/2/2015

Name of Facility	Street Address, City, State, Zip Code
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 11/14/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	1/15/2016	15425	12/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/22/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 07W2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00116

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245372**
2.STATE VENDOR OR MEDICAID NO.
(L2) **428540900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUKES LUTHERAN CARE CENTER**
(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/02/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 12/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **11/14/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/14/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/12/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/14/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	12/03/2015	15425	12/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/22/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245372	A. Building 01 - MAIN BUILDING 01 B. Wing	11/18/2015

Name of Facility	Street Address, City, State, Zip Code
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0154	10/22/2015	ID Prefix Reg. # NFPA 101 LSC K0155	10/22/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/kfd	Date: 12/03/2015	Signature of Surveyor: 35482	Date: 11/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245372	02 - BUILDING 2	11/18/2015

Name of Facility	Street Address, City, State, Zip Code
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0154	10/22/2015	ID Prefix Reg. # NFPA 101 LSC K0155	10/22/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/kfd	Date: 12/03/2015	Signature of Surveyor: 35482	Date: 11/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245372	03 - 2008 ADDITION	11/18/2015

Name of Facility	Street Address, City, State, Zip Code
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0154	**10/22/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	**10/22/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/kfd	Date: 12/03/2015	Signature of Surveyor: 35482	Date: 11/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 07W2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00116

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245372**
2.STATE VENDOR OR MEDICAID NO.
(L2) **428540900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUKES LUTHERAN CARE CENTER**
(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/22/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 11/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/03/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Informal Dispute Resolution - 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
Kathryn.serie@state.mn.us
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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an assessment to determine whether a resident was capable to self-administer medication for 4 of 4 residents (R6, R13, R50, and R32) observed to self-administer nebulizer treatment. Findings include: R6's physician orders dated 9/3/15, included DuoNeb (medication used to treat spasm of the bronchi) 3 milliliter (ML) solution four times a day (QID) for emphysema.	F 176	F176 SELF-ADMINISTRATION OF DRUGS St. Luke's Lutheran Care Center's Self-Administration of Medication Policy and Procedure and Nebulizer Administration Protocol are well defined and comply with applicable requirements. Residents who self-administer their medications should be assessed and have demonstrated the ability to set up and self-administer medications as	11/14/15

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

Electronically Signed | 11/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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
F 176	Continued From page 1 R6's quarterly Minimum Data Set (MDS) dated 7/21/15, indicated R6 required extensive assist for mobility and to move between locations in room and corridor. In addition, the MDS indicated the resident's diagnoses included anxiety. When the medical record was reviewed, it lacked an assessment related to R6's ability to self-administer medications. During observation of medication administration on 10/20/15, at 6:51 p.m. licensed practical nurse (LPN)-A was observed to administer a nebulizer treatment to R6. LPN-A placed the prescribed medication into the nebulizer receptacle, attached the receptacle to the mouthpiece, turned on the nebulizer machine and handed the mouthpiece and attached receptacle to R6 and walked out of the room. R13's physician orders dated 10/1/15, included DuoNeb 3 ML solution QID for chronic obstructive pulmonary disease (COPD.) During observation of medication administration on 10/21/15, at 10:49 a.m. LPN-B was observed to administer a nebulizer treatment to R13. LPN-B placed the prescribed medication into the nebulizer receptacle, attached the receptacle to the face mask, turned on the nebulizer machine and placed the mask over R13's nose and mouth. R13 stated "I don ' t know what I'm doing." LPN-B stated "I'll set my timer" and left the room. R13's quarterly MDS dated 9/24/15, identified R13 had been cognitively impaired, required extensive assist for mobility, and total dependence to move between locations in room and corridor. When the medical record was	F 176	prescribed. Residents who may be left alone during the course of the nebulizer treatments but do not set up their medications or initiate their treatments are assessed to determine if they are safe to be left alone during the course of the nebulizer treatment. It is facility policy that the resident is assessed for their ability to keep the nebulizer mask on or hand-held mouth piece in place throughout the treatment. Nursing staff set a timer for when the nebulizer treatment is due to be done and check to assure that the treatment is completed before shutting off the machine. If the resident demonstrates the capability of being left alone during the course of the nebulizer treatment, a note to that effect needs to be made in the Integrated Progress Notes, a physician's order is obtained and a care plan entry is written in this regard and reviewed quarterly by the interdisciplinary team. A review was conducted of the records of the 4 residents cited in this deficiency. Documentation of an assessment, physician order and care plan entry that is reviewed quarterly by the interdisciplinary team is in place. Nursing staff members involved in administering medications are accountable for following the facility policy regarding self-administration of medications and the nebulizer administration protocol. Nursing Department staff members are required to attend an in-service that will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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
F 176	Continued From page 2 reviewed, it lacked an assessment related to R13's ability to self-administer medications. 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 mask covering the nose and mouth, a mist had been noted coming from the nebulizer. LPN-B removed the mask, turned off the nebulizer and walked out of the room. R32's quarterly MDS dated 8/28/15, indicated R32 required extensive assist for activities of daily living and had functional limitations on one	F 176	cover the following topics: 1. Review of facility Self-Administration of Medications Policy and Procedure 2. Review of facility Nebulizer Administration Protocol The in-service sessions will be held on 11/12/15 and 11/13/15. Staff members who are unable to attend will be required to complete a make-up packet. The RN Education Coordinator, Evening Shift Coordinator and Night Shift Coordinator or their designees will observe at least one random medication pass monthly to ensure that nursing staff are following the facility policy for nebulizer administration. Results will be reported to the Director of Nursing to guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	

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	245372	A. BUILDING _____ B. WING _____	10/22/2015

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F 176	Continued From page 3 side of the body. When the medical record was reviewed, it lacked an assessment related to R32's ability to self-administer medications. On 10/22/15, at 8:22 a.m. registered nurse (RN)-A indicated the facilities self-administration assessment for nebulizer use consisted of an observation the resident left nebulizer administration equipment on when in use. RN-A stated a nurse's note would be entered in the medical record to identify they had been observed and left it on. RN-A stated "It's not a full assessment we just make sure they leave it on and don't take it off." RN-A verified R6, R13, R50, and R32's had not been assessed and determined safe by the interdisciplinary team. On 10/22/15, at 10:07 a.m. the director of nursing (DON) verified the facility practice had been observation that the resident did not remove nebulizer administration equipment while in use. DON stated the facility had not included nebulizer medication administration as self-administration that needed to be assessed. On 10/22/15, at 10:32 a.m. the consulting pharmacist stated a resident could be left alone with a nebulizer if determined appropriate and further stated there needed to be a process to determine that the mental and functional status of a resident is assessed. Facilities self-medication administration policy revised 7/2011 did not include nebulizer medication information.	F 176		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		11/14/15

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F 329	Continued From page 4 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to establish parameters for as needed (PRN) pain medication for 1 of 6 residents (R13) reviewed for unnecessary medications. Findings Include: R13 was admitted to the facility on 1/27/14, the admission face sheet revealed diagnoses to include stage 4 pressure ulcer of right and left	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Medications were reviewed for R13. Frequent pain assessments were done in order to manage resident's pain post fractures/sprain/heel ulcers. For each pain assessment, nursing staff completed a pain flow sheet every shift for 5-7 days. Pain assessments were initiated to determine effectiveness of pain	

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F 329	Continued From page 5 heel. R13's quarterly Minimum Data Set (MDS) dated 9/24/15, identified R13 was cognitively impaired. R13's physician orders dated 10/1/15, included Tylenol (non-narcotic pain medication) 325 milligrams (mg) two tablets every four hours as needed (PRN) for pain, and oxycodone (opioid narcotic) 5 mg, 1 to 2 tablets every four hours PRN for breakthrough pain. The physician orders lacked parameters of when to give a non-narcotic PRN pain medication versus when to give an opioid narcotic PRN pain medication. The physician order also lacked parameters of when to give one or two tablets of oxycodone. R13's PRN medication administration record (MAR) revealed PRN oxycodone had been administered thirty two (32) times from 10/2/15 through 10/21/15. Review of documentation for thirty (30) of the 32 administrations, two tablets were given. The MAR included a pain scale for R13 to rate pain from 1-10 (least-most). However, the pain ratings documented on the MAR varied between 5 and 10, with multiple areas blank when R13 had been administered 2 tablets of oxycodone. Parameters were not identified, indicating when to administer one (1) vs two (2) tablets when R13 rated the pain. PRN Tylenol was not administered during this time. On 10/22/15, at 7:12 a.m. licensed practical nurse (LPN)-B stated there were no parameters for either medication. LPN-B was unable to identify when she would have given the PRN Tylenol vs when she would have administered one or two oxycodone tablets.	F 329	management plan when resident had adjustments in pain medication. Both verbal and nonverbal pain ratings were obtained from the resident as well as intervention and response. Results of the flow sheet were reviewed by the RN Resident Care Coordinator and a pain management plan was written. Based on these findings, the resident's physician gave the following order with parameters for pain medication on 10/23/15: Oxycodone 5mg po 1 tab for pain 1-4; 2 tabs for pain 5-10 every 6 hours prn. Licensed nursing staff members are accountable for following the facility process for establishing prn pain medication parameters. All Nursing Department staff members are required to attend an in-service session that will cover the following topics: 1. Review of process for establishing prn pain medication parameters The in-service sessions will be held on 11/12/15 and 11/13/15. Staff members who are unable to attend will be responsible for completing a make-up packet. A consultant pharmacist reviews St. Luke's Lutheran Care Center resident records monthly. Irregularities are reported to the attending physician and Nursing Department staff; a summary of his findings is reported to the Quality Assessment and Assurance Committee	

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F 329	Continued From page 6 On 10/22/15, at 8:36 a.m. registered nurse (RN)-A verified PRN parameters for PRN Tylenol and oxycodone had not been found in the medical record and further verified the PRN Tylenol had not been given from 10/2/15 through 10/21/15. RN-A stated R13 would have been unable to understand a pain scale rating. On 10/22/15, at 10:02 a.m. the director of nursing verified the above and stated if there is a dose range the order would need to be specific. On 10/22/15, at 10:32 a.m. the consultant pharmacist verified parameters for PRN medication needed to be included in the physician order. Request made for current policy on PRN pain medication administration was not provided.	F 329	quarterly. On a monthly basis, the Director of Nursing or her designee will randomly monitor resident records for unnecessary drugs, to assure compliance with F329 Unnecessary Drug regulation. Results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will reevaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist	F 428	F428 DRUG REGIMEN REVIEW	11/12/15

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F 428	Continued From page 7 identified clear parameters for use of PRN (as needed) pain medication for 1 of 6 residents (R13) reviewed for unnecessary medications. Findings Include: R13 was admitted to the facility on 1/27/14, the admission face sheet revealed diagnoses to include stage 4 pressure ulcer of right and left heel. R13's quarterly Minimum Data Set (MDS) dated 9/24/15, identified R13 was cognitively impaired. R13's physician orders dated 10/1/15, included Tylenol (non-narcotic pain medication) 325 milligrams (mg) two tablets every four hours as needed (PRN) for pain, and oxycodone (opioid narcotic) 5 mg, 1 to 2 tablets every four hours PRN for breakthrough pain. The physician orders lacked parameters of when to give a non-narcotic PRN pain medication versus when to give an opioid narcotic PRN pain medication. The physician order also lacked parameters of when to give one or two tablets of oxycodone. R13's PRN medication administration record (MAR) revealed PRN oxycodone had been administered thirty two (32) times from 10/2/15 through 10/21/15. Review of documentation for thirty (30) of the 32 administrations, two tablets were given. The MAR included a pain scale for R13 to rate pain from 1-10 (least-most). However, the pain ratings documented on the MAR varied between 5 and 10, with multiple areas left blank when R13 had been administered 2 tablets of oxycodone. Parameters were not identified, indicating when to administer one (1) vs two (2) tablets when R13 rated the pain. PRN	F 428	Medications were reviewed for R13. Frequent pain assessments were done in order to manage resident's pain post fractures/sprain/heel ulcers. For each pain assessment, nursing staff completed a pain flow sheet every shift for 5-7 days. Pain assessments were initiated to determine effectiveness of pain management plan when resident had adjustments in pain medication. Both verbal and nonverbal pain ratings were obtained from the resident as well as intervention and response. Results of the flow sheet were reviewed by the RN Resident Care Coordinator and a pain management plan was written. On 11/12/15, the Director of Nursing reviewed survey findings with consultant pharmacist. Consultant pharmacist stated his record review showed the following: R13 complained of and exhibited a high level of pain; nursing assessments detected the higher level of pain. Higher dose of analgesic was administered due to the higher level of pain. He stated that monitoring confirmed that the higher dose of analgesic controlled pain, therefore he did not feel there were any irregularities. The consultant pharmacist reviews St. Luke's Lutheran Care Center resident records monthly, looking for medication irregularities. The consultant pharmacist will report findings to the attending physician and the Director of Nursing. On an ongoing basis, the Consultant Pharmacist's report will be summarized at the quarterly Quality Assessment and	

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F 428	Continued From page 8 Tylenol was not administered during this time. Monthly Consultant Pharmacy Medication Review form reviewed. On 10/6/15 the consultant pharmacist reviewed R13's record, no problems were identified. On 10/22/15, at 10:02 a.m. the director of nursing (DON) stated she would have expected the pharmacist to identify and report PRN medications had no parameters for use. On 10/22/15, at 10:32 a.m. the consultant pharmacist verified parameters for PRN medication had not been identified for R13.	F 428	Assurance Committee Meeting. The Director of Nursing is responsible for overall compliance with this regulation.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		11/14/15

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F 441	Continued From page 9 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to change gloves after contact with a wound during a dressing change for 1 of 2 residents (R13) observed for a dressing change. In addition the facility failed to clean a nebulizer machine between use for 2 of 4 residents (R6, R32) observed during medication administration observation. Findings include: R13's physician order dated 10/12/15, included daily dressing change to left and right heel wounds. On 10/21/15, at 10:20 a.m. a dressing change was completed on left and right heel wounds by licensed practical nurse (LPN)-C and registered nurse (RN)-A. The following was observed:	F 441	F441 INFECTION CONTROL On 10/21/15, Director of Nursing met with RN-A. RN-A reported that she did not change her gloves after measuring wound because she thought she had not touched the wound while measuring. RN-A stated that technically she should have changed her gloves. On 10/23/15, copies of the facility policy and procedure for glove use and the World Health Organization's "Your 5 moments for HAND HYGIENE" handout were posted in each resident care area for review by nursing staff. In order to assure best practice, the Director of Nursing contacted a representative of Salter Labs,	

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F 441	Continued From page 10 -Left heel wound: After LPN-C removed the soiled dressing RN-A put on clean gloves and measured the wound using a paper wound measuring ruler. RN-A was observed to touch wound bed and wound edges during measurement. After measurement was completed RN-A held residents left leg while LPN-C completed the treatment. RN-A was observed to touch R13's bedding, hem of residents left pant leg, and top of residents left foot with the soiled gloves. After completion of the dressing change, RN-A removed the soiled gloves, washed hands and donned clean gloves. -Right heel: After LPN-C removed the soiled dressing from R13's right heel RN-A measured the wound using a paper wound measuring ruler. RN-A was observed to touch the wound bed and wound edges during the measurement. After measurement of the wound was completed, RN-A held residents right leg while LPN-C completed the treatment. RN-A was observed to touch R13's bedding, clothing, and right leg with the soiled gloves. On 10/21/15, at 10:40 a.m. RN-A verified clean gloves had come in contact with the wounds during dressing change on both heels and that the gloves had not been changed before touching R13's bedding, clothing, and skin. On 10/22/15, at 10:29 a.m. the director of nursing (DON) stated the expectation had been that gloves were to be changed when soiled prior to touching clean items. Policy and procedure for glove use dated 6/15/15 gloves read "Gloves should always be changed between patients and between clean and	F 441	manufacturer of nebulizer kits, and revised the facility procedure for hand-held/mask nebulizer and inhaler spacer cleaning and maintenance to include rinsing in-between each use along with taking pieces apart and placing on a cloth to air dry. Per Salter Labs, nebulizer kits will continue to be soaked in antibacterial detergent and warm water for 30 minutes, rinsed and allowed to air dry 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 policy and procedure for glove use. Licensed nurses and trained medication aides will be accountable for following the facility's procedure for hand-held/mask nebulizer and inhaler spacer cleaning. All Nursing Department staff members are required to attend an in-service session that will cover the following topics: 1. Policy and procedure for glove use 2. Hand hygiene 3. Hand-Held/Mask Nebulizer and Inhaler Spacer Cleaning and Maintenance Policy and Procedure The in-service sessions will be held on 11/12/15 and 11/13/15. Staff members 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 then ongoing on a monthly basis, will randomly monitor the cleaning of nebulizer	

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F 441	Continued From page 11 contaminated sites on same patient." NEBULIZER EQUIPMENT: R6's physician orders dated 9/3/15, included DuoNeb (medication used to treat spasm of the bronchi) 3 milliliter (ML) solution four times a day (QID) for emphysema. During observation of medication administration on 10/20/15, at 6:51 p.m. LPN-A entered R6's room with DuoNeb medication vial. R6's nebulizer medication cup and mouth piece were noted to be connected, hanging on the nebulizer machine. The medication cup contained liquid. LPN-A disconnected the mouthpiece, emptied the medication vial into the cup, reattached the mouth piece, started the nebulizer and handed it to the resident. LPN-A did not empty the residual liquid from the medication cup prior to pouring medication from the vial into the cup. On 10/20/15 at 6:58 p.m. LPN-A stated R6's nebulizer medication cup and mouth piece should have been emptied and dried after it was last used at 4:00 p.m. and verified the medication cup had contained liquid. LPN-A stated the facility procedure had been to disconnect the medication cup and mouth piece and set them on a cloth to dry between use, and further stated the equipment was cleaned and rinsed once daily. 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	F 441	equipment to ensure compliance with facility procedure. Results will be reported to the Director of Nursing. Results of the random audit will also be included in the quarterly Infection Control Report prepared for the Quality Assessment and Assurance Committee. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 441	Continued From page 12	F 441		

wheelchair, with a nebulizer mask covering the nose and mouth. LPN-B removed the mask, disconnected the medication cup and mask and placed them on a cloth.

On 10/21/15, at 11:04 a.m. LPN B reported nebulizer administration equipment was not cleaned or rinsed between use and stated "but they are cleaned on evening shift."

On 10/22/15, at 10:25 a.m. the DON verified the facility procedure for nebulizer medication equipment had been to let air dry between use and cleaned and rinsed once daily. DON stated the facility follows Centers for Disease Control and Prevention (CDC) recommendation for nebulizer cleaning.

On 10/22/15, at 10:32 a.m. the consultant pharmacist reported nebulizer equipment needed to be rinsed each time it is used and stated because the residents' mouth and nose had touched those pieces there is an increased chance of bacterial growth.

Recommendations of CDC and the Healthcare Infection Control Practices guidelines dated August 2003 included between treatments on the same patient, small-volume medication nebulizers (in-line and hand-held) should be cleaned, disinfected, rinsed with sterile water (if rinsing is needed) and dried in the prevention of transmission of microorganisms. The report read, "This report updates, expands, and replaces the previously published CDC "Guideline" for Prevention of Nosocomial Pneumonia".

The facility Hand-held Nebulizer and Inhaler Spacer Cleaning and maintenance policy updated

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F 441	Continued From page 13 3/2014 included "Prevention of Nosocomial Bacterial Pneumonia, CDC 1994."	F 441		

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

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ST LUKES 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 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 19 Existing 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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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 01 of St. Luke's Lutheran Care Center was constructed as follows: The original building was constructed in 1963, is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1969 building addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1975 building addition 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.	K 000		

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 000	Continued From page 2 The facility has a capacity of 112 beds, and had a census of 89 at time of the survey.	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, 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 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 154	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 I. POLICY 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 sprinkler system is out of service, for more than 4 hours in	10/22/15

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K 154	Continued From page 3	K 154	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: i. Facility Administrator * Margaret 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	

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 154	Continued From page 4	K 154	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 sprinkler system is out of service, directing them to: i. 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 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.	

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K 154	Continued From page 5	K 154	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 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	

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K 154	Continued From page 6	K 154	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 open in any fashion); • Oxygen cylinders/containers not in use are properly stored; • Electrical hazards are promptly reported and remedied;	

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K 154	Continued From page 7	K 154	• 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 When the impaired system has been restored to normal working order: a. The following persons will	

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K 154	Continued From page 8	K 154	be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. 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 Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling:	

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K 154	Continued From page 9	K 154	(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. _____ _____ _____	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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: 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 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 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire alarm system.	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	10/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 155	Continued From page 10 This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 155	I. POLICY 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 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: i. Facility Administrator * Margaret	

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K 155	Continued From page 11	K 155	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: i. 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	

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K 155	Continued From page 12	K 155	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	

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K 155	Continued From page 13	K 155	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. 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	

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 155	Continued From page 14	K 155	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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY BLUE EARTH, MN 56013**

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K 155	Continued From page 15	K 155	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 When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2015**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 155	Continued From page 16	K 155	* 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 Email: 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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 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	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	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.	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 154		10/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 154	Continued From page 2 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, 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 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 154	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 I. POLICY 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 sprinkler 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 sprinkler at St Luke's Lutheran	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 154	Continued From page 3	K 154	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: i. Facility Administrator * Margaret 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	

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	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 154	Continued From page 4	K 154	* 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 sprinkler system is out of service, directing them to: i. 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 154	Continued From page 5	K 154	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. 2. Fire watch personnel will: a. Have no other duties	

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	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 154	Continued From page 6	K 154	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 154	Continued From page 7	K 154	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 When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. Head of Maintenance * John Gieser – (H) 507-526-5436 (C) 507-525-5818	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 154	Continued From page 8	K 154	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 154	Continued From page 9	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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: 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 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 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	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 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	10/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 155	Continued From page 10	K 155	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 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: i. Facility Administrator * Margaret 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	

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K 155	Continued From page 11	K 155	* 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: i. 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	

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	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES 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 155	Continued From page 12	K 155	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 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	

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	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 155	Continued From page 13	K 155	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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K 155	Continued From page 14	K 155	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. 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	

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	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**10/22/2015**

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K 155	Continued From page 15	K 155	administrator or facility safety officer. F. System(s) restored to service When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. 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	

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K 155	Continued From page 16	K 155	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 Email: 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **03 - 2008 ADDITION** B. WING _____	**10/22/2015**

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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. 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.

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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.	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 154		10/22/15

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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. 9.7.6.1 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, 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 unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 154	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 I. POLICY 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 sprinkler 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 sprinkler at St Luke's Lutheran Care Center is out of service.	

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K 154	Continued From page 3	K 154	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: i. Facility Administrator * Margaret 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	

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K 154	Continued From page 4	K 154	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 sprinkler system is out of service, directing them to: i. 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 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 unit and/or fire alarm annunciator indicating that the system, or part thereof,	

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K 154	Continued From page 5	K 154	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.	

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K 154	Continued From page 6	K 154	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 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.	

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K 154	Continued From page 7	K 154	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 When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. Head of Maintenance * John Gieser – (H) 507-526-5436 (C) 507-525-5818 iii. Local fire chief or fire marshal	

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K 154	Continued From page 8	K 154	* 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. _____ _____ _____	

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(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 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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: 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 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 On facility tour between 9:00 AM and 12:30 PM on 10/22/2015, documentation review revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	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 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	10/22/15

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	245372	A. BUILDING **03 - 2008 ADDITION** B. WING _____	**10/22/2015**

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K 155	Continued From page 10	K 155	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 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: i. Facility Administrator * Margaret 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	

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K 155	Continued From page 11	K 155	* 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: i. 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	

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K 155	Continued From page 12	K 155	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 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	

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K 155	Continued From page 13	K 155	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 open in any fashion); • Oxygen cylinders/containers not in	

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K 155	Continued From page 14	K 155	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	

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K 155	Continued From page 15	K 155	When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator * Margaret Brandt (W) 507-526-2184 (C) 515-320-0443 ii. 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	

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K 155	Continued From page 16	K 155	Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: (651) 769-7779 Email: 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.	