DEPARTMENT OF HEALTI	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICA	ID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID:	0GDF
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	FE SURVEY AGENCY	Fac	cility ID: 00571
1. MEDICARE/MEDICAID PROVIDE (L1) 245067 2.STATE VENDOR OR MEDICAID N (L2) 470618800		3. NAME AND AI (L3) ST LUCAS (L4) 500 SOUTH (L5) FARIBAUL	CARE CENTI EAST FIRST	ER	(L6) 55021	 TYPE OF ACTION: Initial Termination Validation 	<u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF ((L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	,	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After Control 	9. Other omplaint
6. DATE OF SURVEY 10/1. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 07/27	DATE: (L35)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	1 109 (L18)	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Servic 7. Medical Direct	ces Limit or
13.Total Certified Beds	109 (L17)	BXNot in Compliance Requirement	e with Program ents and/or Appli	ied Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 109	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Gloria Derfus, Supervisor		1	0/14/2014	(L19)	Anne Kleppe, Enforcer	ment Specialist	10/14/2014_(L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RH	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
 19. DETERMINATION OF ELIGIBIL X 1. Facility is Eligible to P 2. Facility is not Eligible 			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (He e :	CFA-1513)
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L3	30)
OF PARTICIPATION 01/01/1967	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Me	ARY et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for whitehawar	07-Provider S 00-Active	Status Change
(L27)	B. Rescind S	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)	10/07/2014		(L33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5067

October 14, 2014

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, MN 55021

Dear Ms. Acosta:

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 October 7, 2014 the above facility is certified for or recommended for:

109 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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.

St Lucas Care Center October 14, 2014 Page 2

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

October 14, 2014

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

RE: Project Number S5067024

Dear Ms. Acosta:

On September 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 28, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 1, 2014 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 August 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 28, 2014, effective October 7, 2014 and therefore remedies outlined in our letter to you dated September 17, 2014, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Ane Klagse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245067	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/13/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
ST	LUCAS CARE CENTER		500 SOUTHEAST FIRST STRE FARIBAULT, MN 55021	ET

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)	ltem		(Y5) I	Date
ID Prefix Reg. # LSC	483.15(h)(2)		Correction Completed 10/07/2014	ID Prefix Reg. # LSC	F0278 483.20(g) - (j)		Correction Completed 10/07/2014		ID Prefix Reg. # LSC	483.20(d), 483	3.20(k)(1)	Correction Completed 10/07/2014
	F0315 483.25(d)		Correction Completed 10/07/2014	ID Prefix Reg. #			Correction Completed 10/07/2014			F0322 483.25(g)(2)		Correction Completed 10/07/2014
ID Prefix Reg. # LSC	F0329 483.25(l)		Correction Completed 10/07/2014	Reg. #			Correction Completed		Reg. #			Correction Completed
Reg. #							Correction Completed		Reg. #			
Reg. #				– <i>– –</i>					D.a			
State Agen	су	Reviewed GD/AK Reviewed	-	Date: 10/14/2 Date:	Signature 014 Signature		•		18	623	Date: 10/13 Date:	3/2014
	to Survey Com 8/28/2	-	:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245067	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILI	(Y3) Date of Rev DING 01 10/1/2014	
Name of Facility	Street A	ddress, City, State, Zip Code	
ST LUCAS CARE CENTER		SOUTHEAST FIRST STREET BAULT, MN 55021	

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	ſ	Y5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 09/25/2014	ID Prefix		Completed 09/10/2014	ID Prefix			Completed 09/17/2014
	NFPA 101	_		NFPA 101		-	NFPA 101		
LSC	K0038	-	LSC	K0062		LSC	K0144		
		Correction			Correction				Correction
ID Drofin		Completed	ID Drefit		Completed	ID Drofin			Completed
		-							_
Reg. # LSC		-	Reg. # LSC			Reg. # LSC			_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-				ID Prefix			_
Reg. #		-	Reg. #			Reg. #			_
L3C		-	LOU			L3C			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-				ID Prefix			_
Reg. # LSC		-	Reg. #			Reg. #			_
LSC		-	LSC			LSC			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix			ID Prefix			_
Reg. #		-	Reg. #			Reg. #			_
LSC		-	LSC			LSC			_
Reviewed E	By Reviewed	ІВу	Date:	Signature of Sur	veyor:			Date:	
State Agen	cy PS/AK		10/14/201	14		258	22	10/01	/2014
Reviewed E	3y Reviewed	Ву	Date:	Signature of Sur	veyor:			Date:	
CMS RO									
Followup t	o Survey Completed or	n:		Check for any Unco					
	8/26/2014			Uncorrected Defic	iencies (CM	3-2307) Sent to	me racility?	YES	NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	AID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	Π	D: 0GDF
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	FE SURVEY AGENCY	F	Facility ID: 00571
1. MEDICARE/MEDICAID PROVIDE (L1) 245067 2.STATE VENDOR OR MEDICAID No. (L2) 470618800		3. NAME AND AI (L3) ST LUCAS (L4) 500 SOUTH (L5) FARIBAUL	CARE CENTI EAST FIRST	ER	(L6) 55021	 TYPE OF ACTION Initial Termination Validation 	N: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU	·	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other
6. DATE OF SURVEY 08/28 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN 07/27	IG DATE: (L35)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	109 (L18)	Complianc	nce With equirements te Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Ser 7. Medical Dire	vices Limit ector
13.Total Certified Beds	109 (L17)	X B. Not in Con Requirem	npliance with Pro- ents and/or Appli		* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOW	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 109	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Lisa Hakanson, HPR-Diet	ary Specialist	(09/30/2014	(L19)	Anne Kleppe, Enforce	ment Specialist	10/03/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
 DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572 ol Interest Disclosure Stmt (e :	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (1	L30)
OF PARTICIPATION 01/01/1967	BEGINNINC	6 DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		<u>TARY</u> 1eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		leet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
	A. Suspension	n of Admissions:	7.40		04-Other Reason for Withdrawal	07-Provide 00-Active	r Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6900

September 17, 2014

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

RE: Project Number S5067024

Dear Ms. Acosta:

On August 28, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Supervisor Metro C Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 Saint Paul , Minnesota 55164-0900 Email: Gloria.derfus@state.mn.us

Telephone: (651) 201-3792 Fax: (651) 201-3790

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 October 7, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 7, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 28, 2014 (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 February 28, 2015 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5067s14

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
d plan c	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245067	B. WING		08/28/2014
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
T LUCA	S CARE CENTER			500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	۱ (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉT
F 000	INITIAL COMMENT	-S	F 000		· ·
1 000	The facility's plan of as your allegation of a	of correction (POC) will serve f compliance upon the		RECEIVE	Ð
	Department's accept bottom of the first p be used as verificat	otance. Your signature at the age of the CMS-2567 form will ion of compliance.		SEP 3 0 2014	
	revisit of your facility validate that substa	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with		COMPLIANCE MONITORING I LICENSE AND CERTIFICA	2000 Marine Constant - 198
F 253 SS=E	483.15(h)(2) HOUS MAINTENANCE SE		F 253	 Corrective action: All cabinetry in question has been 	10-7-
ie.]	maintenance servic	ovide housekeeping and es necessary to maintain a d comfortable interior.	nol und	A plan for carpet replacement will be in place by 10-7-2014.	
4	by:	IT is not met as evidenced (al holy	 The soiled incontinence product a bundles wrapped in toilet paper w 	ere
	review, the facility fa environment provide	ed an appearance adequate	est	immediately bagged and removed from the room upon discovery.	
	potential to affect al unit. In addition, the	comfort. This had the I 39 residents on the first floor facility failed to ensure a safe ment was provided for 1 of 1		The bathroom floor of R32 was cleaned immediately upon discovery.	2
	resident (R176) who unkempt.	ose bathroom floor was		Resident R32 was reassessed for urinary incontinence and interventions were care planned a	nd
	Findings include:	7 a.m. an environmental tour		implemented to address refusals o assistance, odors, improperly	f
	conducted with the director (ESD). The	7 a.m. an environmental tour environmental services following issues were noted room and television area:		disposing of soiled toilet paper, an the increased urine frequency.	iu .

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			1.1	FORM	09/17/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245067	B. WING			08/:	28/2014
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STILLC	AS CARE CENTER				0 SOUTHEAST FIRST STREET		
51 200	RO OARE OENTER			FA	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	 Veneer on severation of the ped and marreed were were visible whad been removed, door and raw panel the cabinet above the and had holes in the sink, a recess area sink drain plumbing through broken cine cabinetry was easily area. The ESD expanders area subject to covert it for was described as a subject to funding, had recently hired area expected more time. The carpeting in floor was darkened below the cabinets wall. The soiled carrow and west wall cabinet and west wall cabi	al cabinets were noted to be d. Drill holes and large holes where old hardware and locks One cabinet was missing a ing edges were visible, and he refrigerator lacked doors e frame. Below the east wall had exposed water tap and by with tubing and pipe visible der block. The ill-repaired y visible to residents using the lained that the area used to be nd had been an ongoing or resident use. The project "work in progress," which was The ESD stated the facility additional help, and he ely repairs. television room on the first and matted along the edges and the sink along the east opet extended around two in along the bases of the south hets to the refrigerator. rpet directly in front of the red and stained with dark	F 2	253	 Action as it applies to others: The policy and procedure for Environmental Maintenance was reviewed and remains current. The policy and procedure for Care Planning was reviewed on 9-22- 2014 and remains current. The policy and procedure for Bladder assessment and Retraining was reviewed on 9-22-2014 and remains current. Other residents who experience urinary incontinence will have their most recent bladder assessments and care plans reviewed to ensure accuracy and to assist each resident in maintaining the highest practicable level of well-being. Licensed nursing staff will be re- educated on the policy and procedure for Bladder Assessment and Retraining. 	ıd t	
	cleaned on Wedne needed. The carpe 10 years prior, "in t a couple bids for ca years ago, but corp request had since t some of the carpet authorization had n carpet replacement	plained that carpets were sdays, with spot cleaning as t had been installed more then he early 90's possibly. We got arpet replacement a couple borate turned it down." A capital been submitted, and although ing had been replaced, not been given for further t. The ESD verified the carpet been stained, and he stated it a Obsolete Event ID:0GDF1			Licensed nursing staff will be re- educated on the policy and procedure for Care Planning. Maintenance staff will be re- educated on the policy for Environmental Maintenance. 3. Date of completion: 10-7-201		t Page 2 of 34

		AND HUMAN SERVICES				FORM	: 09/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.2010/2.5022-01		PLE CONSTRUCTION G		E SURVEY IPLETED
		245067	B. WING	÷		08/	28/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY; STATE, ZIP CODE		
ST LUCA	AS CARE CENTER				500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		*0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253		ge 2 ned again that afternoon.	F2	253	 3 4. Recurrence will be prevented by: 		
	Inspections directed inspected and any	ed Physical PlantMonthly d, "The rooms shall be deficiencies shall be cheduled for repair."			Random weekly environmental audits will be completed to ensure the facility maintains a sanitary, orderly, and comfortable interior.		
ά.	4:00 p.m. Observations of the floor between the floor between the floor between the floor between the solied toilet part of the between the survey of the solied toilet part of the solied toilet part to the between the solied toilet part to the between the solied toilet part of the between the solied toilet part the between smeller to the solied to th				Random weekly chart audits will b conducted to ensure residents who are found to have urinary incontinence have current bladder assessments and appropriate care planned interventions to ensure the receive the necessary care and services. Additionally, weekly random visua audits will be conducted to ensure staff carry out the plan of care. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA	y 1	
	The pervasive urine the room. An opene floor by the bed alo toilet paper. R32 ex receive help with to preferred a bed bat incontinent product self-performed bed At 2:30 p.m. a nurs R32 wrapped up so she was unsure wh NA-B explained the of items on the floor	 p.m. R32 was interviewed. e odor was again detected in ed incontinent product was on ng with bundles wrapped in kplained she did not like to vileting or bathing, and th. She changed her soiled is daily on her own, and baths weekly. ing assistant, (NA)-A, said omething in toilet paper, but hat it was she was wrapping. e staff picked up and disposed it in R32's room and bathroom nout the day. NA-A added R32 			 committee to determine the need for ongoing monitoring. 5. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing, Director of Environmenta Services and/or designee 		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0GDF11 Facility ID: 00571

If continuation sheet Page 3 of 34

		I AND HUMAN SERVICES & MEDICAID SERVICES					FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR				E SURVEY
		245067	B. WING				08/	28/2014
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADI	DRESS, CITY, STATE, ZI	P CODE		
STLUCA	AS CARE CENTER				EAST FIRST STREET			
	1				LT, MN 55021			1.196.54
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (E	PROVIDER'S PLAN OF C ACH CORRECTIVE ACTI ISS-REFERENCED TO TI DEFICIENC	ON SHOULD	BE	(X5) COMPLETION DATE
F 253	did refuse help with	toileting and incontinence urine odor was present in the	F 2	253			5.47	15
~	problem with stress used an incontinent with changing of the to continue self-ma was to ensure R32 incontinent briefs. The resident preferred to the sink and did not The goal was to ma bathing skills. Inter- adequate time before	rised 1/3/14, revealed a s incontinence of bladder. R32 t brief and was independent e brief. The goal was for R32 nagement. The intervention had an adequate supply of The care plan also noted the o clean up independently by t like a whirlpool or shower. aintain independence with ventions were to allow re offering assistance, clean baths per her preference, and soap.		~		8		
F 278 SS=D	(DON) was intervie a former staff perso bathe. They were the person who might be The DON was unawe bundles in R32's base tried to encourage le and changing cloth adamant about what not, however, deve addressing refusals improperly disposite to ensure a sanitary for R176. 483.20(g) - (j) ASSI ACCURACY/COOF	a.m. the director of nursing wed. The DON explained that on was able to get R32 to rying to find another staff be able to deliver care to R32. ware of wet toilet paper and athroom. She explained they her to accept help with toileting ing, but the resident was very at she wanted. The facility did lop a specific plan for s of help, odors, and g of soiled toilet paper for R32 y environment was maintained ESSMENT RDINATION/CERTIFIED ust accurately reflect the	F 2	278				
					**	16		Desc 1 10
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: 0GDF1	1	Facility ID: 0057	(1	If continuat	ion sheet	Page 4 of 34

3

		AND HUMAN SERVICES	ž			FORM	: 09/17/2014 1APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		TE SURVEY MPLETED
		245067	B. WING	÷		08/	/28/2014
NAME OF I	PROVIDER OR SUPPLIER			L .	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER				500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 278	resident's status. A registered nurse i each assessment w participation of heal A registered nurse i assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessment penalty of not more assessment. Clinical disagreement material and false s This REQUIREMENT by: Based on observator review, the facility f identify adverse sid non-pharmacologic	must conduct or coordinate with the appropriate lth professionals. must sign and certify that the pleted. to completes a portion of the sign and certify the accuracy of assessment. d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each	F	278	 Immediate corrective action: Resident (R102) was comprehensively reassessed for adverse side effects and non- pharmacological interventions. It care plan was updated to include use of antidepressant medications monitoring of adverse side effect support and encouragement of the residents mood and non- pharmacological interventions. Resident (R 74) was comprehensively reassessed for adverse side effects, non- pharmacological interventions fo sleep, support and encouragement the resident's mood and the objective for the use of the psychoactive medication. The ca plan for R 74 was updated to incl the use of psychotropic medication and non-pharmacological interventions for sleep. Action as it applies to otherss The policy and procedure Writin Care Area Assessment's was reviewed on 9-22-14 and remains current. The policy and procedure for use Psychopharmacological Medicat was reviewed on 9-22-2014 and remains current. 	the , s, e t of re ude ons : g s of	10-7-14
	rinaings include:				the second s		
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 0GDF1	1	F	Facility ID: 00571 If continu	ation shee	et Page 5 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Share Same and		LE CONSTRUCTION		ATE SURVEY
	of the second seco		A. BUILD	ING	i <u> </u>		
		245067	B. WING	-		0	8/28/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER				00 SOUTHEAST FIRST STREET		
				-1	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
F 278	Continued From pa	ae 5	F 2	278	Other residents who receive	H	
	5 2	seated in the common area			psychopharmacological medica		
		a.m. no behaviors were noted.			will be comprehensively reasses	sed	
		served seated in the common			for adverse side effects, non-	1	
	area on 8/28/14, at	1:00 p.m. no behaviors noted.			pharmacological interventions, support and encouragement of t	10	
					resident's mood and the benefit		
		n's Orders dated 7/28/14,			necessity of the use of the		
		ropion (antidepressant) 300 1 Celexa (antidepressant) 20			medication.		
	mg.				Licensed nursing staff will be re	-	
	D100's initial Minim	um Data Set (MDS) dated			educated on the policy for Writi		S.
99	8/4/14, identified dia	agnoses which included			Care Area Assessments.		
		DS indicated R102 had pressant within the last seven			Licensed nursing staff will be re	-	
		energy. The resident needs			educated on the policy for the u	se of	
	extensive assistance (ADLs) with one to the	e with activities of daily living			Psychoactive Medications.		
	(ADES) with one to t				3. Date of completion: 10-7-2	.014	
	Notes from Internal did indicate R102's	had Physician's Progress medicine dated 8/4/14, which depression; however, there d clinical rationale for the			 Recurrence will be prevented by: 	ed	
		sity for, the use of multiple			Random weekly chart audits wi	l be	
		e same pharmacological			conducted to ensure residents w	ho	
		did not indicate R102 was			receive psychopharmacological		
	under a psychologis	st care.			medications are comprehensive		
					assessed for adverse side effects non-pharmacological intervention		13
		ssessment dated 8/8/14,			support and encouragement of t		
		ived two antidepressants and e CAA also indicated R102			resident's mood and the benefit		
	expressed a desire	to return to the community.			necessity of the use of the		
		ecessary drug evaluation was			medication.		
		uld have indicated R102					
		nedications for the same			Audits will be completed for a	14	
	diagnosis. The sect	ion for drug related discomfort			period of 90 days and audit resu	Its	
		equired treatment and/or			will be reviewed by the QA committee to determine the nee	for	
	prevention was left	blank for dehydration, lack of			ongoing monitoring.	1 101	
	exercise, urinary rel	tention, reduced dietary bulk, npaction and dry mouth.			l ongoing monitoring.		

		AND HUMAN SERVICES			±	FORM	09/17/2014 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1888 N		E CONSTRUCTION		E SURVEY IPLETED
		245067	B. WING			08/	28/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER				OO SOUTHEAST FIRST STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	indicated R102 rec and as needed bow constipation. In add (diuretic) daily whic adverse side effect The CAAs lacked of for the benefit of, o multiple medication antidepressant class monitor the bowel s lacked evidence of assess the side eff mouth, constipation of the antidepressa address how the fa R102's mood beha	ician's Orders dated 7/28/14, eived Colace (stool softener) vel suppositories for dition, R102 received Lasix ch would be indicative of s dry mouth and dehydration. documented clinical rationale r necessity for, the use of	F		 The correction will be monitore Ongoing compliance will be monitored by the Director of Nursing and/or designee. 	d by:	Y
	monitor for adverse antidepressants or Record (MAR) date however, a thoroug completed for the o R102's care plan p and the following w address the dehyd however, the care antidepressant use effects, the resider encouragement of	the Medication Administration ed 8/1/14 through 8/28/14, gh assessment had not been duplicate antidepressant use. rinted 8/28/14, was reviewed vas noted. The care plan did ration and constipation, plan lacked evidence of the e, monitoring of adverse					-3
	On 8/28/14, at 10: (DON) verified card 567(02-99) Previous Version	15 a.m. the director of nursing e plan approaches and s Obsolete Event ID: 0GDF		F	acility ID: 00571 If continue	ation shee	et Page 7 of 34

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		245067	B. WING _		08	/28/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
ST LUCA	S CARE CENTER			500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From pa non-pharmacologic developed for R102	al interventions had not been	F 27	8		
	distributed by Amer revised on 7/8/13, r hydrochloride exter cause serious side Medication Guide f these serious side reported in studies include weight loss skin rash, sweating shakiness, stomacl dizziness, trouble s fast heartbeat, sore often. In studies of	kage Insert packaged and ican Health Packaging last noted the "Bupropion nded-release tablets (XL) can effects. Read this entire or more information about effects. Common side effects of major depressive disorder , loss of appetite, dry mouth, n, ringing in the ears, n pain, agitation, anxiety, leeping, muscle pain, nausea, e throat, and urinating more seasonal affective disorder, ts included weight loss, as."			3 1 1	
	by Forest Laborato 7/14/14, noted the side effects in peop nausea, sleepiness anxious, trouble sle sweating, shaking,	ge Insert and Label Information ries, Inc. last revised on following: "Common possible ble who take Celexa include: s, weakness, dizziness, feeling eeping, sexual problems, not feeling hungry, dry mouth, ea, respiratory infections, and			E .	
	8/27/14, at approxi staff person preser	walking down the hallway on mately 8:00 a.m. and told a nt, "I don't know how I am breakfast." No behaviors the breakfast meal				

		AND HUMAN SERVICES	з			FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245067	B. WING			08/	28/2014
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	(hydrochloric acid) sleep and depressi Klonopin (anticonver- morning and 1 mg psychotic dementia Risperdal (antipsyc (QD) for agitation of The medical record Notes from Internal which did indicated Trazodone use and been admitted to the the locked dementing general population the nursing home. she feels that [R74 was no documenter benefit of, or necessing psychotic medication indicate R74 was un R74's quarterly Min 7/15/14, identified of depression. The M the antidepressant little or no energy, overeating. The residence of the sing toileting a independent with m R74's Care Area A 1/23/14, revealed F and had depression discomfort which wa and/or prevention v constipation/fecal i Physician's Orders	100 milligrams (mg) for latent on ordered on 1/10/14, ulsant drug) 0.5 mg in the in evening ordered for a ordered on 1/11/14, and shotic) 0.25 mg one time a day ordered 8/8/14. I had Physician's Progress I Medicine dated 3/31/14, R74's Klonopin and the note revealed "[R74] has ne nursing. She is no longer in a ward and is doing well in the of the long term care side of The social worker reports that] is bored." However, there d clinical rationale for the sity for, the use of the ordered on. The medical did not under a psychologist care. himum Data Set (MDS) dated diagnoses which included DS indicated R74 had received within the last seven days, and had poor appetite or was sident needed supervision with and hygiene and was nobility. ssessment (CAAs) dated R74 received antidepressants n. The section for drug related yould have required treatment	F2	278			

Event ID: 0GDF11

Facility ID: 00571

If continuation sheet Page 9 of 34

		AND HUMAN SERVICES			FORM): 09/17/2014 1 APPROVED). 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second sec	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245067	B. WING		08	/28/2014
	PROVIDER OR SUPPLIER	L	N.	STREET ADDRESS, CITY, STATE, ZIP CC 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	constipation). Even antidepressant for consequences of a the resident was le hallucinations (acc 8/28/14, R74 was b hallucinations and sleep). The CAAs la facility was going to the potential risk of use of the antipsyc non-pharmacologic Also, the CAAs did was going to interv symptoms regardin poor appetite or ov did not indicate wh regarding the psyc section was left bla monitor the bowel evidence of how the the bowel status w psychotropic medic the facility was to c and medication use On 8/28/14, at app director of nursing did not include the medications and the for sleep. The DOR care plan to include and be updated as psychotropic medic The Klonopin Pack Information by REI	a though R74 received sleep, the section for adverse in antidepressant exhibited by ft blank for insomnia and ording to the care plan printed being monitored for the Trazodone was ordered for acked evidence of how the passess the side effects for further constipation from the hotic medication and the cal interventions for sleep. not address how the facility rene for R74's mood behavior ng little energy, tiredness and rereating. In addition, the facility at the overall objective was hoactive medication as that ank. Even though the facility did status of R74, the CAAs lacked the facility was going to address ith regards to the prescribed cation. The CAAs did reveal care plan for the depression e.	F 2		ontinuation shee	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.00 1.02	IPLE CONSTRU			E SURVEY. PLETED
		245067	B. WING			08/2	28/2014
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE EAST FIRST STREET		
ST LUCA	S CARE CENTER			A TRANSPORTATION OF A DOLLAR DATE	T, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD IS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278 F 279 SS=D	problems with walk dizziness, depressi problems with mem The Trazadone Pay Information By DIR identified the most trazodone hydroch sleepiness, dizzine vision The Psychopharma revised 3/13 indica non-medication inte attempted to assist mood, behavior, or beginning a medica neuroleptics, hypro antidepressants an medication will be to to treat a specific of directed staff to mo the physician as lis 483.20(d), 483.20(COMPREHENSIVI A facility must use to develop, review comprehensive pla The facility must de plan for each resid objectives and time medical, nursing, a needs that are iden assessment.	ing and coordination, on, constipation, fatigue, and hory. ckage Insert and Label ECT RX last revised 6/10/14 common side effects of loride tablets included ss, constipation, and blurry acologic Medication Use policy ted, "To assure all erventions have been with resident's [sic] displaying sleep concerns prior to ation. This policy refers to all otics, sedatives, id anxiolytics. Antipsychotic used only when it is necessary ondition. "The policy also onitor and report side effects to ted in the procedures." k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 2	79 1. Ir The ca was up strateg direct reside ADL' addrest tasks anxiet	nmediate corrective action: are plan for Resident (R65) pdated to include: proactive gies for social adjustment, ion for staff to encourage int involvement in performing s and decision making and to ss: refusal to preform self-care depression, social isolation, ty, somatization and resident's vior towards staff.	9	10-7-14

Event ID: 0GDF11 Facility ID: 00571

If continuation sheet Page 11 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES			23 - 5	FORM	: 09/1//2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Sec. Same		LE CONSTRUCTION		E SURVEY
	4	245067	B. WING	·		08/	28/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OTINOA	C CADE CENTER				500 SOUTHEAST FIRST STREET		
SILUCA	S CARE CENTER			F	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE '	(X5) COMPLETION DATE
F 279	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including furner under §483.10(b)(4) This REQUIREMEN by: Based on observative review, the facility f was developed for for psychosocial ad Findings include: Surveyor: Hakanso R65 was observed eating breakfast in remaining in her row walking and nerve	ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment). NT is not met as evidenced tion, interview and document ailed to ensure a care plan 1 of 1 resident (R65) reviewed justment. n, Lisa on 8/27/14, at 8:40 a.m. bed. She reported she liked om because of difficulty pain. She felt she received too	F2	279	 Action as it applies to others: The policy and procedure for the Care Planning process was reviewed on 9-22-2014 and remains current. Resident interview and Social Service assessment reviews will be conducted for other residents to ensure residents who display or verbalize mental or psychosocial adjustment difficulty have appropriate comprehensive care plans with measurable objectives and timetables to meet the resident highest practicable level of mental and psychosocial well-being. The interdisciplinary team (IDT) and licensed nursing staff will be re educated on the policy and procedure for the Care Planning Process. Date of completion: 10-7-201 Recurrence will be prevented 	?s	
	many medications, issue with her phys in the facility fewer	and planned to address the ician. R65 had been residing than 60 days.			Random weekly resident interview and chart audits will be conducted	w	10
	area that read, "I and environment." The to express accepta arrangement. Proa adjustment were no observe for change as needed. The plat to how they should	ted 6/3/14 included a focus m adjusting ok to my new goal was for R65 to continue nce of current living ctive strategies to address ot listed, rather staff was to as in acceptance and intervene an lacked direction for staff as intervene if problems were so lacked identification of R65's			and chart audits will be conducted to ensure residents who display o verbalize mental or psychosocial adjustment difficulty have appropriate care planned interventions and timetables to assist the resident in attaining the highest practicable level of menta and psychosocial well-being.	r	

Facility ID: 00571

If continuation sheet Page 12 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/17/2014 1APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 Beerland		E CONSTRUCTION		TE SURVEY MPLETED
		245067	B. WING	s		08	/28/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	AS CARE CENTER				00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	for depression, anx addition, noted R65 dressing, grooming statement, "I want to grooming and bath staff to compete the interventions for R6 independence. It w confused when not resident to continue care and well-being observe, but lacked related to involving decision making. T activities R65 enjoy assist the resident weekly visits, and e was noted R65 spe experienced pain w activity. A quality of various activities th to remind and invite interventions were radio, and to provid encourage to atten The Care Area Ass psychosocial well-t listed depression, of living (ADL), mood problems and char factors that might in Documentation by described R65 as f psychosocial issue bed, and experience	self-care, to leave her room, or iety, and somatization. In 5 required assistance with and bathing, with a goal to be well dressed and neatly participate in my dressing, ing." Interventions directed a resident's ADLs, but lacked 55 to work toward as noted R65 became feeling well, with a goal for the e make decisions regarding g. Interventions were to d other direction for staff the resident in care and he plan identified various yed. Interventions were to with television, radio, provide encourage to attend groups. It ent most time in her room, and yith a low tolerance for physical fife focus area identified tat R65 enjoyed. The goal was e to activities of interest. the to assist with TV, music, and le weekly contact visits to d groups of interest.	F	279	Audits will be completed for a period of 90 days and audit res will be reviewed by the QA committee to determine the new ongoing monitoring. 5. The correction will be monitor Director of Nursing and/or designee.	ed for	

Event ID: 0GDF11 Facility ID: 00571

If continuation sheet Page 13 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/17/2014 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Shares				E SURVEY IPLETED
		245067	B. WING			08/	28/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER			1.1	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	well-being was to b plan. The CAA for p indicated that R65 y antidepressant and Documentation for antidepressant and used, the resident y facility, and had dia disorder (symptoms depression, and an side effects and ovy medication. The ph medications and th as needed. The CA use was to be addr Weekly Medicare re to 8/11/14, indicate assist of two staff y (ADL). R65 was ide cares, incontinent of required full assistant was unwilling to pe of her time in the ro light and then not re review indicated that require full assistant becoming more will subsequent review R65 had been refut treatments. On 8/2 all of her time in he therapy, and althou self-care tasks, she R65's initial Minimu	CAA indicated psychosocial e addressed on R65's care osychotropic drug use was treated with an a hypnotic (to promote sleep). the CAA indicated hypnotic medication was was newly admitted to the gnoses including somatization s without real disease), xiety. Staff were to observe for erall effectiveness of armacist was to review e physician would be updated A indicated psychotropic drug ressed in R65's care plan. eview meetings from 7/10/14 d R65 required extensive with activities of daily living entified as non-compliant with of bowel and bladder, and ance from staff because she rform self-care. She spent all bom, often activating the call emembering why. The 8/15/14, at although R65 continued to no from staff, she was ling to help herself. A on 8/21/14, however, noted sing some medications and 8/14, it was noted R65 spent of a was unwilling to do so.		279 Fa		tion sheet	Page 14 of 34

		AND HUMAN SERVICES			С		APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '				E SURVEY IPLETED
		245067	B. WING			08/	28/2014
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	behavioral issues. being very important being somewhat im- experienced some impairment in range extensive assistant Two social service R65's record. On 7 rating was 3, indicat The comment section to return to her prior subsequent assess decline in R65's de of mild depression. notation of the incre- the resident's psyco- behavior, refusals of room. The general social service docu Nursing notes note revealed R65 requires and only left her roor On 8/28/14, at 10:4 (DON) was intervite resisted completing completing herself expect staff to com- also known to be " DON verified care- developed to addre	She cited daily preferences as int and activity preferences aportant. Although she back pain, she had no e of motion, but required ce for ADLs. assessments were noted in /15/14, R65's depression ative of minimal depression. ion indicated R65 was unable or living arrangement. A sment on 8/7/14, revealed a epression rating at 6, indicative . Both assessments lacked a ease in depressive symptoms, chosocial adjustment, negative of care, or isolation in her progress notes did not include imentation. e dated 8/7/14 and 8/8/14, ired assistance of one staff for ing, grooming, toileting and ndependent in eating with set ed to participate in activities	F2	279			

Facility ID: 00571

If continuation sheet Page 15 of 34

and proper to the state of the state of the state of the	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		VG	CON	MPLETED
		245067	B. WING _			/28/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	S CARE CENTER			500 SOUTHEAST FIRST STREET		
11 2007				FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
F 279	Continued From pa	ae 15	F 27			
1 270	The facility's care p directed staff to ens resident-centered p admission and main team throughout th optimal quality of lif	lanning policy dated 8/14,				
F 315 SS=D	achieve or maintair physical and menta	n their highest practicable al abilities. HETER, PREVENT UTI,	F 31	15 1. Immediate corrective ac The soiled incontinence prod		10-7-1
	assessment, the far resident who enters indwelling catheter resident's clinical c	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that s necessary; and a resident		bundles wrapped in toilet pay were immediately bagged an removed from the room upor discovery.	ber d 1	
	who is incontinent of treatment and serv	of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder		immediately upon discovery. Resident R32 was reassessed urinary incontinence and interventions were care plan	for	
	by: Based on observa	NT is not met as evidenced tion, interview and document failed to provide services to		implemented to address refus assistance, odors, improperly disposing of soiled toilet pap the increased urine frequency	, er, and	25
	help 1 of 1 residen urinary incontinence	t (R32) improve self-care for		2. Action as it applies to ot		
	Findings include:			The policy and procedure for Planning was reviewed on 9- 2014 and remains current.		-
	4:00 p.m. Observa odors, and two we paper on the floor	as observed on 8/25/14, at tions revealed pervasive urine t, yellow bundles of soiled toilet by the toilet and additional wet oper and tissues under the sink		The policy and procedure for Bladder Assessment and Ret was reviewed on 9-22-2014 remains current.	raining	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/17/2014 APPROVEL . 0938-039
STATEMENT OF DE	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		245067	B. WING			08/	/28/2014
NAME OF PROVID	DER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCAS CA	RE CENTER				SOUTHEAST FIRST STREET RIBAULT, MN 55021		
(X4) ID PREFIX TAG I	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
by the with wet R17 show R17 the stolle the l At 5 urine oper bed R32 with She on h wee On sea sea notion At 2 R32 she NA- of itt peri did care resi At 2 she NA- of itt peri did care resi	R32, reported s bundle of toilet 6 went to the bar wed the survey 6 stated she us soiled toilet pap t toward the sin bathroom smell 45 p.m. R32 w e odor was aga ned incontinent along with bund explained she toileting or bath changed her so toileting or bath changed her so to an urs wrapped up so was unsure wh B explained the ems on the floo odically through refuse help with a dent's room. :45 p.m. NA-C lest and did not nging her brief of to change cloth	 176, who shared the bathroom she had once stepped on a paper with her stocking feet. athroom, opened the door and or the soiled bathroom floor. ed the toilet plunger to move er and tissues away from the k. R176 grimaced and stated ed of urine. as interviewed. The pervasive in detected in the room. An product was on floor by the dles wrapped in toilet paper. did not like to receive help hing, and preferred a bed bath. oiled incontinent products daily lf-performed bed baths a.m. R32 was observed sion area and again a or was emanating from R32. ing assistant, (NA)-A, said omething in toilet paper, but at it was she was wrapping. estaff picked up and disposed r in R32's room and bathroom nout the day. NA-A added R32 toileting and incontinence urine odor was present in the explained R32 was very wish to receive help with or clothes. Staff encouraged ing each day, but sometimes f gentle prodding and 		315	Other residents who experience urinary incontinence will have the most recent bladder assessments care plans reviewed to ensure accuracy and to assist each reside in maintaining the highest practicable level of well-being. Licensed nursing staff will be re- educated on the policy and procedure for Bladder Assessme and Retraining. Licensed nursing staff will be re- educated on the policy and procedure for Care Planning. 3. Date of completion: 10-7-2 4. Recurrence will be prevented by: Random weekly chart audits wi conducted to ensure residents w are found to have urinary incontinence have current bladd assessments and appropriate car planned interventions to ensure receive the necessary care and services to aid in maintaining the highest practicable level of well being. Additionally, Weekly random v audits will be conducted to ensure staff carry out the plan of care.	and ent ent 2014 ed Il be ho ler re they heir l- risual ire	Page 17 of 3

		AND HUMAN SERVICES				FORMA	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	APP1000000			(X3) DATE	
		245067	B. WING			08/2	8/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	AS CARE CENTER	3			00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	reminders. NA-C w in toilet paper, but r picked up off the flor reminded to dispose the toilet. NA-C sai incontinent briefs w often as needed. A licensed social w interviewed at 3:00 was leaving wet toi floor, but was awar R32's Care Area As 9/11/13, for bladde incontinence of urin the problem neede plan. One modifiab psychiatric problem issues or factors w the problem. Staff R32's care plan re- problem with stress used an incontinent with changing of th "dribbling." The go self-management f was to ensure R32 incontinent briefs. resident preferred the sink and did no The goal was to m bathing skills. Inter adequate time befor and trim nails after provide towels and The Minimum Data	as unsure what R32 wrapped made sure the bundles were bor, and the resident was e of tissues and toilet paper in d staff also assured R32 the vere free and to change as orker (LSW)-A was the p.m. She was unaware R32 let paper on the bathroom re she resisted bathing. ssessment (CAA) dated r indicated occasional he (type not specified) noted d to be addressed on the care le factor of psychological or hs was identified, but no other rere identified as contributing to was to "monitor." vised 1/3/14, revealed a s incontinence of bladder. R32 it brief and was independent e brief to manage R32's al was for R32 to continue for peri-cares. The intervention the dan adequate supply of The care plan also noted the to clean up independently by ot like a whirlpool or shower. aintain independence with ventions were to allow ore offering assistance, clean baths per her preference, and d soap.		315	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. 5. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee		Dana 18 of 24
FORM CMS-2	2567(02-99) Previous Version	s Obsolete Event ID: 0GDF	11	Fa	acility ID: 00571 If continuati	on sheet I	Page 18 of 34

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING		08	/28/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12012011
ST LUC	AS CARE CENTER			500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 315	indicated R32 was was frequently inco the MDS noted R32 impaired. R32's inc determined as the indicated R32 was care plan revised of dribbled, and the M R32 was frequently provided the appro- incontinence. On 8/28/14, at 9:00 (DON) was intervie trying to get a psyc regarding the urine DON explained that able to get R32 to 1 another staff perso care to R32. R32 h 8/15/14, after a chat acting in appropria was attempting to s television area at n wet toilet paper and She explained they accept help with to but the resident was she wanted. The fa a specific plan for a odors, improperly of and the increased The facility's 8/14 of individual, resident initiated upon admi interdisciplinary tea stay, to promote op	not on a bladder program and ontinent of urine. In addition, 2 was moderately cognitively continence could not be CAAs dated 9/11/13, had occasionally incontinent, the in 1/3/14, indicated R32 IDS dated 6/12/14, indicated v incontinent. R32's was not priate services to manage the 0 a.m. the director of nursing ewed. She explained they were shological consult for R32 odor and room odor. The it a former staff person was bathe. They were trying to find n who might be able to deliver ad a psychological consult on ange in behavior when she was tely toward other residents and sleep in the chair in the ight. The DON was unaware of d bundles in R32's bathroom. v tried to encourage her to ileting and changing clothing, as very adamant about what acility did not, however, develop addressing refusals of help, disposing of soiled toilet paper,	F3	15		

	I			3-0391
	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		LTIPLE CONSTRUCTION (X3) DATE SURV DING	VEY
	245067	B. WING		14
NAME OF PROVIDER OR SUPPLIER ST LUCAS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) PLETION DATE
F 315Continued From page 19 encouraged to achieve of practicable physical and 1F 319483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCI.Based on the comprehend resident, the facility must who displays mental or pridificulty receives approprise services to correct the astThis REQUIREMENT is by: Based on observation, in review, the facility failed to was provided for 1 of 1 redisplayed psychosocial at Findings include:R65 was observed on 8/2 eating breakfast in bed. Since with her physician, in the facility fewer than 6R65's care plan dated 6/ area that read, "I am adju environment." The goal of to express acceptance of arrangement. Proactive adjustment were not listed observe for changes in a as needed. The plan lac to how they should intervironment.	r maintain their highest mental abilities. R AL DIFFICULTIES asive assessment of a ensure that a resident sychosocial adjustment riate treatment and assessed problem. not met as evidenced nterview and document to ensure social services esident (R65) who adjustment issues. 27/14, at 8:40 a.m. She reported she liked ecause of difficulty She felt she received too blanned to address the R65 had been residing 50 days. 3/14 included a focus usting ok to my new was for R65 to continue of current living strategies to address ed, rather, staff was to acceptance and intervene ked direction for staff as	F 3	 Immediate corrective action: A new Social Service assessment was completed for Resident (R 65) on 9-2-2014. A referral was completed on 9-18- 2014 for Resident (R 65) to be seen by the facility psychologist. Action as it applies to others: The policy and procedure for the Care Planning process and Mental Health Referrals was reviewed on 9-22-2014 and remains current. Other residents will have their most recent Social Services assessment and care plan reviewed to ensure the assessments and care plans remain current and assist each resident in maintaining their highest level of mental and psychosocial well-being. Residents found to exhibit difficulty with mental or psychosocial adjustment will have mental health referrals completed, per facility policy. The interdisciplinary team (IDT) and licensed nursing staff will be re- educated on the care planning and Mental Health Referral Policies. 	7-14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 09/17/2014 APPROVED . 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1500000 2.0410 P.OC.		E CONSTRUCTION		E SURVEY	
		245067	B. WING	R		08/	28/2014	
NAME OF PROVIDER OR SUPPLIER ST LUCAS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 319	noted. The plan also refusal to perform s for depression, anx addition, the care pl assistance with drea with a goal stateme and neatly groomed dressing, grooming directed staff to con- lacked interventions independence. It wa confused when not resident to continue care and well-being observe, but lacked related to involving decision making. Th activities R65 enjoy assist the resident w weekly visits, and en- was noted R65 spen experienced pain w activity. A quality of various activities that to remind and invite interventions were to radio, and to provide encourage to attend of care lacked evide interventions that ad changes in her life. The Care Area Asse psychosocial well-bo- listed depression, de living (ADL), mood of problems and chang factors that might in	b lacked identification of R65's elf-care, to leave her room, or iety, and somatization. In an noted R65 required ssing, grooming and bathing, nt, "I want to be well dressed I. I want to participate in my and bathing." Interventions hpete the resident's ADLs, but a for R65 to work toward as noted R65 became feeling well, with a goal for the make decisions regarding . Interventions were to other direction for staff the resident in care and he plan identified various ed. Interventions were to with television, radio, provide nocurage to attend groups. It nt most time in her room and ith a low tolerance for physical life focus area identified at R65 enjoyed. The goal was to activities of interest. The o assist with TV, music, and e weekly contact visits to I groups of interest. The plan ence of the facility providing idressed R65's adapting to	F 3	319	 Date of completion: 10-7-20 Recurrence will be prevented by: Random weekly resident intervier and chart audits will be conducted to ensure residents who display of verbalize mental or psychosocial adjustment difficulty have appropriate care planned interventions, facility arranged mental health service, and current social service assessments. Audits will be completed for a period of 90 days and audit result will be reviewed by the QA committee to determine the need ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee. 	l w d r t		

Facility ID: 00571

If continuation sheet Page 21 of 34

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.000	TIPLE CONSTRUCTION		
			ING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	245067	B. WING		08/	28/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ARE ARE REPORTED TO THE ADDE	ULD BE	(X5) COMPLETION DATE
psychosocial issue bed, and experience inability to return to arrangement. The 0 well-being was to b plan. The CAA for p indicated that R65 antidepressant and Documentation for antidepressant and used, the resident y facility, and had dia disorder (symptom depression, and an side effects and ov medication. The ph medications and th as needed. The CA use was to be addu Weekly Medicare n to 8/11/14, indicate assist of two staff y (ADL). R65 was idd cares, incontinent required full assists self-care. She spen often activating the remembering why. that although R65 assistance from sta willing to help hers 8/21/14, however, some medications was noted R65 spe only coming out for	having cognitive impairment, s, spent most of her time in her previous living CAA indicated psychosocial be addressed on R65's care osychotropic drug use was treated with an I a hypnotic (to promote sleep). the CAA indicated I hypnotic medication was was newly admitted to the agnoses including somatization s without real disease), inxiety. Staff was to observe for erall effectiveness of narmacist was to review is physician would be updated AA indicated psychotropic drug ressed in R65's care plan. review meetings from 7/10/14 ed R65 required extensive with activities of daily living entified as non-compliant with of bowel and bladder, and ance from staff to perform int all of her time in the room, a call light and then not The 8/15/14, review indicated continued to require full aff, she was becoming more elf. A subsequent review on noted R65 had been refusing and treatments. On 8/28/14, it ent all of her time in her room r therapy, and although she lf-care tasks, and she was		B19	nuation sheet	Page 22 of 3-

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	0: 09/17/2014 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and a subscript		E CONSTRUCTION		TE SURVEY MPLETED
2		245067	B. WING			08	8/28/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER			07.0	00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 319			F	319			
	moderately cognitive behavioral issues. R65 had mood synd depressed and hop in doing things, and two to six days out preferences as beil preferences being she experienced so impairment in rang extensive assistant Two social service R65's record. On 7 rating was 3, indica The comment sect to return to her prior subsequent assess decline in R65's de of mild depression notation of the incr the resident 's psy behavior, refusals	7/15/14, indicated R65 was yely impaired, but presented no However, the MDS did indicate optoms of feeling down, beless, had little or no interest d feeling tired with no energy of the week. She cited daily ng very important and activity somewhat important. Although ome back pain, she had no e of motion, but required ce for ADLs. assessments were noted in /15/14, R65's depression ative of minimal depression. ion indicated R65 was unable or living arrangement. A sment on 8/7/14, revealed a epression rating at 6, indicative . Both assessments lacked a ease in depressive symptoms, chosocial adjustment, negative of care, or isolation in her progress notes did not include					
	revealed R65 requ all transfers, dress hygiene, and was up help. She refus and only left her ro	e dated 8/7/14 and 8/8/14, ired assistance of one staff for ing, grooming, toileting and independent in eating with set ed to participate in activities from for therapy. 45 a.m. the director of nursing	e ^e				
	(DON) was intervie	ewed. She explained R65 g cares she was capable of	11	Fa	acility ID: 00571 If contin	nuation she	et Page 23 of 34

.3

		AND HUMAN SERVICES		55		FORM	09/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Sec. Same		E CONSTRUCTION		E SURVEY PLETED
		245067	B. WING		-	08/2	28/2014
NAME OF F	PROVIDER OR SUPPLIER	2			TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET		
ST LUCA	S CARE CENTER				ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
					•	n ne verse se k	
F 319			F	319			
	expect staff to com also known to be "i DON verified care developed to addre	saying it was her right to plete them instead. R65 was mean and rude" to staff. The plan approaches had not been ess R65's refusal to perform dress her behavior toward					
F 322 SS=D	directed staff to en resident-centered p admission and main team throughout the optimal quality of li included in the pro- achieve or maintain physical and menta provided care and and maintain the h psychosocial funct 483.25(g)(2) NG T RESTORE EATING Based on the comp resident, the facility (1) A resident who alone or with assiss tube unless the residemonstrates that unavoidable; and (2) A resident who gastrostomy tube of treatment and serv pneumonia, diarrh metabolic abnormatic	plans be initiated upon intained by the interdisciplinary be resident's stay, to promote fe. Each resident was to be cess and encouraged to in their highest practicable al abilities. R65 was not services to assist her to reach ighest level of mental and ioning. REATMENT/SERVICES -	F	322	 Immediate corrective action LPN-A received written counsel for failing to follow facility polic and procedure for Medication Administration though Gastric T on 9-23-2014. LPN-A performed a return demonstration for Medication administration through a Gastric Tube on 9-23-2014. 	ing cy Tube	10.744

Facility ID: 00571

If continuation sheet Page 24 of 34

DEPARTMENT OF HEALTH				PRINTED: 09/17/2014 FORM APPROVED MB NO. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	B. WING _		08/28/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
by: Based on observa review, the facility f protocols for admin through gastrostom appropriately for 1 for medication adm Findings include: R16's medication a conducted the mon approximately 8:30 nurse (LPN)-A. LPI R16 to be administ (inserted into the s and/or nutrition). M muscle spasticity) Carbidopa-Levodo disease), and cran healthy urinary trac crushed and mixed with approximately water. The LPN dia administration of th medication administ observed to be run check the residual prior to the medica	NT is not met as evidenced tion, interview and document failed to ensure facility histration of medications hy (G-tube) were implemented of 1 resident (R16) reviewed hinistration via G-tube.	F 32	 Action as it applies to other The policy and procedure for Medication Administration thro a Gastric Tube was reviewed on 23-2014 and remains current. Licensed nursing staff will be re educated on the policy for Medication Administration thro a Gastric Tube. Date of completion: 10-7-2 Recurrence will be prevent by: Random weekly visual audits w be conducted to ensure staff re compliant with facility policy a procedure for Medication Administration thorough a Gas Tube. Audits will be completed for a period of 90 days and audit rest will be reviewed by the QA committee to determine the new ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee. 	ugh 19- ugh 014 ed vill main nd tric ults

		AND HUMAN SERVICES			12	FORM	: 09/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245067	B. WING	;		08/	/28/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER				500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
· (X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ı ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322	60 cc syringe on the medications into the the medications into the then flushed with 1 verified the medica prior to administration A nursing note date severely impaired of all needs. A diagnor revealed R16 had of sclerosis, paralysis neurogenic bladder Medications Review directed staff to add consistent with thos observation and the did not specify the administered toget On 8/28/14, at 11:4 (DON) explained s administered indivi policy. The DON ve did not specify medications through the facility's written Administration through included procedure administration: "1) crushed and adminis specifically ordered more than one medications and the clamp feeding tubin feeding, insure plut clean. 9) Check for	tarted. LPN-A then placed a e gastric tube, put the mixed e syringe, and administered rough the tube. The tube was 5 ccs of tap water. LPN-A tions had been mixed together ion. ed 12/31/13, showed R16 had cognition and relied on staff for stic list dated 8/28/14, diagnoses which included e agitans (Parkinson's-like) r, and urinary tract infection. A w Report dated 8/28/14, minister the medications se administered during the e Medications Review Report medications could be her. 45 a.m. the director of nursing he expected medications to be dually, according to the facility erified R16's Physician Orders dications could be administered n policy, Medication e. Each medication should be histered separately, unless d by physician to administer d at a time8) If feeding is medication administration, ng. When separating tube from g is placed to keep open end r residual and placement by		322		nuation sheet	Page 26 of 34
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 0GDF1	1	F	Facility ID: 00571 If contin	nuation sheet	Page 26 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/17/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245067	B. WING		08/28/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	S CARE CENTER			500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
			10	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHOU	JLD BE	COMPLETION DATE
F 322	attaching sixty (60) gastric tube and ge 150 ml. a. If meet r content, stop proce amount of residual, into stomach. Clarr appearance of gas tube is patent and i content appears, th lining of the stomac After establishing th correct position, cla syringe, without pis open the clamp/un approximately 15-3 meds with 5-10 ml medications, or spi physician. If MD [p	nge 26 ml (milliliter) piston syringe to antly pulling back no more than esistance as aspirate stomach dure. b. If no resistance, note Return gastric contents back op gastric tube. c. The tric content implies that the n the stomach. d., If no gastric ne tube may be against the ch or may be obstructed. 10) hat the tube is patent and in amp or kink tube. 11) Reattach ston, to the end of the tube and kink the tubing. Flush tube with 60 ml water. 12) Administer water flush in-between ecifically ordered amount per hysician] orders more than one stered at a time, specific flush		322		
F 329 SS=D	must be included in administered, flush Clamp/plug tube w feeding. (For reside regulation, the phy the amount of wate and in-between me the policy regardin placement of the fe medication adminsiter identified in the po 483.25(I) DRUG R UNNECESSARY I Each resident's dru unnecessary drug drug when used in	n order. After last medication with 15-30 ml warm water. hen completed or reattach to ent who requires fluid sician's order should include er to be used for the flushing eds.)" LPN-A did not follow g checking for the residual and eeding tube prior to the sitration. In addition, the LPN the medications seperately as licy. EGIMEN IS FREE FROM	F	 Immediate corrective ac Resident (R102) was comprehensively reassessed adverse side effects. 	for	10-7-14

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0GDF11 Facility ID: 00571

		AND HUMAN SERVICES			01		APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Strange Strangers		PLE CONSTRUCTION G		E SURVEY
		245067	B. WING	S		08/	28/2014
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	A ANDE OFNITED				500 SOUTHEAST FIRST STREET		
STLUCA	AS CARE CENTER				FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 329	indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessa as diagnosed and o record; and resider drugs receive grad behavioral interven	nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F	32	to include the use of antidepressal medications, monitoring of adver- side effects, support and encouragement of the residents mood and non-pharmacological interventions. Resident (R 74) was comprehensively reassessed for adverse side effects, non- pharmacological interventions for sleep, support and encouragemen the resident's mood, and the objective for the use of the psychoactive medication. The care plan for R 74 was updat to include the use of psychotropic medications and non- pharmacological interventions for sleep.	r t of ed c	
	by: Based on observa review, the facility f non-pharmacologic residents (R102, R medications. Findings include: R102 was observe on 8/27/14, at 9:30 In addition, was ob area on 8/28/14, at R102 had Physicia	NT is not met as evidenced tion, interview and record failed to identify and develop cal interventions for 2 of 5 74) reviewed for unnecessary d seated in the common area a.m. no behaviors were noted. served seated in the common t 1:00 p.m. no behaviors noted. an's Orders dated 7/28/14, propion (antidepressant) 300			 2. Action as it applies to others The policy and procedure for the of Psychopharmacological Medications was reviewed on 9-2014 and remains current. Other residents who receive psychopharmacological medicati will be comprehensively reassess for adverse side effects, non-pharmacological interventions, support and encouragement of th resident's mood and the benefit on necessity of the use of the medication. 	use 22- ons sed e	

Facility ID: 00571

If continuation sheet Page 28 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/17/201 APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S. Same		CONSTRUCTION		E SURVEY
		245067	B. WING			08/	28/2014
	PROVIDER OR SUPPLIER			500	EET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST FIRST STREET RIBAULT, MN 55021		17
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 329	milligrams (mg) and mg. R102's initial Minim 8/4/14, identified dia depression. The MI received the antide days and little or no extensive assistant (ADLs) with one to The medical record Notes from Internal did indicate R102's was no documente benefit of, or necess medications from th class. The medical under a psychologi R102's Care Area A revealed R102 rece had depression. Th expressed a desire The section for unr left blank which wo received duplicate diagnosis. The sec which would have n prevention was left exercise, urinary re constipation/fecal in However, the Phys indicated R102 rece and as needed bow constipation. In add (diuretic) daily whic adverse side effect	d Celexa (antidepressant) 20 um Data Set (MDS) dated agnoses which included DS indicated R102 had pressant within the last seven of energy. The resident needs ce with activities of daily living two staff assist. I had Physician's Progress medicine dated 8/4/14, which depression; however, there d clinical rationale for the estity for, the use of multiple ne same pharmacological did not indicate R102 was st care. Assessment dated 8/8/14, eived two antidepressants and ne CAA also indicated R102 to return to the community. necessary drug evaluation was uld have indicated R102 medications for the same tion for drug related discomfort required treatment and/or blank for dehydration, lack of etention, reduced dietary bulk, mpaction and dry mouth. ician's Orders dated 7/28/14, eived Colace (stool softener) vel suppositories for dition, R102 received Lasix ch would be indicative of is dry mouth and dehydration. documented clinical rationale		329 Facilit	 Licensed nursing staff and the interdisciplinary team (IDT) wire-educated on the policy for Psychopharmacological Medicuse. 3. Date of completion: 10-7. 4. Recurrence will be preven by: Random weekly chart audits w conducted to ensure residents receive psychopharmacological intervent support and encouragement of resident's mood and the benefinecessity of the use of the medication. Audits will be completed for a period of 90 days and audit rewill be reviewed by the QA committee to determine the netionaging monitoring. 5. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee. 	ation 2014 ted fill be who il ely ts, tions, the it or sults sed for	Page 29 of

*

		AND HUMAN SERVICES				FOR	D: 09/17/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A State Accession		PLE CONSTRUCTION G	(X3) DA	TE SURVEY
		245067	B. WING	;		08/28/2014	
NAME OF I	PROVIDER OR SUPPLIER	······································			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET		
ST LUCA	S CARE CENTER			- ×	FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 329	multiple medication antidepressant class evidence of how the the side effects for constipation and de but also by the use CAAs did not addres to address R102's of reveal the facility we depression and me R102's medical recomonitor for adverse antidepressants on Record (MAR) date however, a thoroug completed for the de R102's care plan pl and the following we address the dehyde however, the care pl antidepressant use effects, the residen encouragement of energy and being to interventions. On 8/28/14, at 10:1 (DON) verified care non-pharmacologic developed for R102 The bupropion Pac distributed by Amer revised on 7/8/13, hydrochloride exter	r necessity for, the use of s from the same s. The CAAs also lacked e facility was going to assess the potential risk of dry mouth, hydration not only by the Lasix of the antidepressants. The ess how the facility was going mood behavior. The CAAs did as to care plan for the dication use. ord indicated the facility did e side effects of the the Medication Administration ed 8/1/14 through 8/28/14, th assessment had not been luplicate antidepressant use. rinted 8/28/14, was reviewed ras noted. The care plan did ration and constipation, plan lacked evidence of the the monitoring of adverse t's support and R102's mood behavior of little ired, and non-pharmacological 15 a.m. the director of nursing e plan approaches and cal interventions had not been 2. ckage Insert packaged and rican Health Packaging last noted the "Bupropion inded-release tablets (XL) can effects. Read this entire		329		inuation she	et Page 30 of 3

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 09/17/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A State State State	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		245067	B. WING	2	08	3/28/2014
) 44088885-54 3 5	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	Medication Guide for these serious side of reported in studies include weight loss, skin rash, sweating shakiness, stomach dizziness, trouble s fast heartbeat, sore often. In studies of common side effect constipation, and ga The Celexa Packag by Forest Laborator 7/14/14, noted the f side effects in peop nausea, sleepiness anxious, trouble sle sweating, shaking,	or more information about effects. Common side effects of major depressive disorder , loss of appetite, dry mouth, , ringing in the ears, n pain, agitation, anxiety, leeping, muscle pain, nausea, e throat, and urinating more seasonal affective disorder, ts included weight loss,	F 32	29		
	8/27/14, at approxir staff person presen	walking down the hallway on mately 8:00 a.m. and told a t, "I don't know how I am breakfast." No behaviors he breakfast meal				
	(hydrochloric acid) sleep and depressi Klonopin (anticonvu morning and 1 mg i psychotic dementia	ved Trazodone HCL 100 milligrams (mg) for latent on ordered on 1/10/14, ulsant drug) 0.5 mg in the n evening ordered for ordered on 1/11/14, and hotic) 0.25 mg one time a day rdered 8/8/14.		· · · · ·	15	à

Facility ID: 00571

If continuation sheet Page 31 of 34

~~

N. S. S. S. S. Market	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	All Survey			MPLETED	
		245067	B. WING		08	3/28/2014	
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
ST LUCA	AS CARE CENTER			500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 329	Continued From pa	age 31	F 3	29			
	Notes from Internal which did indicated Trazodone use and been admitted to the the locked dementi general population the nursing home. she feels that [R74] was no documente benefit of, or necess psychotic medication indicate R74 was u R73s quarterly Min 7/15/14, identified of depression. The Mil the antidepressant little or no energy a overeating. The res	A had Physician's Progress I medicine dated 3/31/14, R74's Klonopin and A the note revealed "[R74] has be nursing. She is no longer in a ward and is doing well in the of the long term care side of The social worker reports that] is bored." However, there d clinical rationale for the sity for, the use of the ordered on. The medical did not inder a psychologist care. imum Data Set (MDS) dated diagnoses which included DS indicated R74 had received within the last seven days and and had poor appetite or was sident needed supervision with and hygiene and was					
	independent with m R74's Care Area As 1/23/14, revealed F and had depression discomfort which w and/or prevention v constipation/fecal in Physician's Orders received Metamuci constipation). Even antidepressant for consequences of a the resident was le hallucinations (acco 8/28/14, R74 was b	nobility. sessment (CAAs) dated R74 received antidepressants n. The section for drug related yould have required treatment was left blank for mpaction. However, the dated 1/11/14, indicated R74 I powder (used to treat n though R74 received sleep the section for adverse in antidepressant exhibited by ft blank for insomnia and ording to the care plan printed					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 09/17/201 APPROVEI . 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1		CONSTRUCTION		E SURVEY
		245067	B. WING			08/	28/2014
	PROVIDER OR SUPPLIER			500	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTHEAST FIRST STREET RIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	22.222	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	sleep). The care pl directs staff to mor signs of delerium a attempt to redirect taken her belongin lacked evidence of assess the side eff further constipation antipsychotic medi non-pharmacologic Also, the CAAs did was going to interv symptoms regardin poor appetite or ov did not indicate wh regarding the psyc section was left bla facility was to care medication use. R74's care plan did n potential risk of the from the psychotron non-pharmaceutica On 8/28/14, at app director of nursing did not include the medications, non-r sleep. The DON st plan to include that as soon as possibl was started. The Klonopin Pack Information by REI revised: 6/3/14, no	an for R74 revised 5/06/14 nitor for confusion and other and further evaluate and to and assure no one is trying to gs or talk about her. The CAAs how the facility was going to fects for the potential risk of n from the use of the		329	ity ID: 00571 If contin		Page 33 of 3

.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY
		245067	B. WING _		08	3/28/2014
	ROVIDER OR SUPPLIER	Ω.		STREET ADDRESS, CITY, STATE, ZIP 0 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	1 SHOULD BE	(X5) COMPLETIC DATE
F 329	dizziness, depress problems with men The Trazadone Pa Information By DIR identified the most trazodone hydroch sleepiness, dizzine vision The Psychopharma revised 3/13, indica non-medication inte attempted to assist mood, behavior, or beginning a medica neuroleptics, hypro antidepressants ar medication will be to treat a specific of directed staff to mo	king and coordination, ion, constipation, fatigue, and nory. ckage Insert and Label ECT RX last revised 6/10/14, common side effects of loride tablets included ess, constipation, and blurry acologic Medication Use policy ated, "To assure all erventions have been t with resident's [sic] displaying sleep concerns prior to ation. This policy refers to all	F 32	9		Σ
						- - V2
*						

RS FOR MEDICARE			IPLE CONSTRUCTION	OMB NO	APPROVED 0938-0391 E SURVEY IPLETED
	245067	B. WING	4	08/	26/2014
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AS CARE CENTER			FARIBAULT, MN 55021		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	(D PREFI) TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
INITIAL COMMENT	ſS	KO			
FIRE SAFETY			Dasok		
THE FACILITY'S P ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS		PUC 9-30-14		
ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS HA	OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN				
Minnesota Departn Fire Marshal Division St Lucas Care Cent substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nate Association (NFPA	nent of Public Safety - State on. At the time of this survey, ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection) Standard 101, Life Safety		RECEIVED		
PLEASE RETURN CORRECTION FC DEFICIENCIES (K-TAGS) TO: Health Care Fire Ir State Fire Marshal 445 Minnesota St.	THE PLAN OF OR THE FIRE SAFETY nspections Division , Suite 145		SEP 2 9 2014 MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISIO	DN_	
RY DIRECTOR'S OR PROVI	DERISUPPLIER REPRESENTATIVE'S SIC	I	ON TITLE A	-	(X6) DATE
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER AS CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT FIRE SAFETY THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT C ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/ ACCORDANCE W A Life Safety Code Minnesota Departm Fire Marshal Divisi St Lucas Care Cer substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nat Association (NFPA Code (LSC), Chap PLEASE RETURN CORRECTION FC DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St. St Paul, MN 55107	IDENTIFICATION NUMBER: 245067 PROVIDER OR SUPPLIER AS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. 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 Lucas Care Center was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St, Suite 145 St Paul, MN 55101-5145, or	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 245067 B. WING PROVIDER OR SUPPLIER 245067 AS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIC PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS K 0 FIRE SAFETY K 0 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. 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 Lucas Care Center was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St, Suite 145	RS FOR MEDICARE & MEDICAID SERVICES PROVIDER OF DEFICIENCIES FCORRECTION (X1) PROVIDERSUPPLIENCIA IDENTIFICATION NUMBER R2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S00 SOUTHEAST FIRST STREET FARIBAULT, MN 55021 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S00 SOUTHEAST FIRST STREET FARIBAULT, MN 55021 SUMMARY STREMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION NO FORMATION) PREFIX TAG INITIAL COMMENTS ID PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION STRUCT REQUENTION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2637 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR VERIFICATION. A LIFE SAFETY SUBSTANTIAL COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR VERIFICATION. A LIFE SAFETY OF YOUR STRIFT THE SUBSTANTIAL COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISION AT the time of this survey, SI Lucas Care Center was found not in substantial compliance with the requirements for participation of National Fire Protection Association (NFPA) Standerd 101, LIFE SAFETY DEFICIENCIES (K-TAGS) TO	SY FOR MEDICARE & MILLICATE & MILLICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONST

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OF NTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	SFOR MEDICARE	a MEDIGAD SERVICES		_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
5		245067	B. WING			08/	26/2014
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr prevent a reoccurre The St Lucas Care different times The building with no bas 1908 and was dete construction, (the 1 health care). In 199 constructed and was (111) construction, 1 -story addition was determined to be of with a full basemen was constructed an Type II (111) constr 1991 an addition was determined to be of with no basement. and the 4 additions type allowed for exit	age 1 Whitney@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. Center was constructed at 5 e original building is a 4-story sement. It was constructed in rmined to be of Type I (332) st and 2nd floor are used for 60 a 1-story addition was as determined to be of Type II with no basement. In 1971 a s constructed and was f Type II (111) construction, it. In 1990 a 1-story addition nd was determined to be of uction, with no basement. In as constructed and was f Type II (111) construction, it. In 1990 a 1-story addition as determined to be of uction, with no basement. In as constructed and was f Type II (111) construction, Because the original building and meet the construction isting buildings, the facility was		000			
	fire alarm system w	sprinklered. The facility has a vith full corridor smoke es open to the corridors that is	1	Fai	cility ID: 00571 If continu	ation she	et Page 2 of 6
FORM CMS-25	57(02-99) Previous versions		•		•		

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

38

If continuation sheet Pag

	MENT OF HEALTH	AND HUMAN SERVICES			FORM	09/17/201 APPROVEI 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
	•	245067	B. WING		08/2	26/2014
	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	notification. The facility has a c	age 2 matic fire department apacity of 109 beds and had a a time of the survey.	K 000			
K 038 SS=D	NOT MET as evide NFPA 101 LIFE SA	t 42 CFR, Subpart 483.70(a) is enced by: NFETY CODE STANDARD nged so that exits are readily nes in accordance with section	K 038	3 The exit discharge elevation in question has been leveled and is now compliant. Other exit discharge elevations were inspected and are compliant.	3	9-25-1
	Based on observa facility failed to ma accordance with th 2000 NFPA 101, S deficient practice of residents. Findings include:	is not met as evidenced by: tion and staff interview, the intain the means of egress in the following requirements of ection 19.2., 7.1.6.2 . The sould affect all 15 out of 77		Periodic weekly inspections of exits will be preformed to assure ongoing compliance. Inspections will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. Ongoing compliance will be monitored by the Director of		
	on 08/26/2014, obs wing required exit elevation change a bottom of steps at	servation revealed, that the 90 discharge has more than 1/2" at top landing area and at the public way.		Environmental Services and/or designee Date of Completion: 09-25-14	а Д	
	This deficient prac	tice was confirmed by the		líli		

e.

Facility ID: 00571

If continuation sheet Page 3 of 6

 $^{\circ}$

		AND HUMAN SERVICES	<u>x</u>		0	MB NC	APPROVE 0. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 08/26/2014		
245067							
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST LUCA	AS CARE CENTER		1) SOUTHEAST FIRST STREET RIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 038	Continued From pa	ge 3	ĸ)38			
	Administrator (JA) a Director (DM) at the	and Facility Maintenance e time of discovery.					
K 062 SS=F	NFPA 101 LIFE SA	FETY CODE STANDARD	K	62			
	continuously mainta condition and are in	sprinkler systems are ained in reliable operating spected and tested .6, 4.6.12, NFPA 13, NFPA 25,				¢۲.	
	This STANDARD is	s not met as evidenced by: ion and staff interview, the					
	facility failed to main in accordance with NFPA 101, Sections 1998 NFPA 25, sec	the requirements of 2000 s 19.3.4.1 and 9.6, as well as tions 9-4.2.1 and 10-2.2. This build affect all 77 residents			The 5-year internal inspections of the check valves was completed on 9-10-2014.		9-10-1
	Findings include:				The 5-year internal inspection of the system pipes was completed on 9-10-2014.		
	on 08/26/2014, a re fire sprinkler inspec indicated the follow				Future ongoing 5-year inspection due dates will be determined based on the previous inspection dates listed on the Fire Marshall's		
	the check valves	5 year internal inspection of 5 year internal inspection of			recommended Annual Inspection form.	- - 	
	-	mentation stating the above			Ongoing compliance will be monitored by the Director of Environmental Services and/or designee	Ē	
	These deficient prac Administrator (JA) a	ctices were confirmed by the and Facility Maintenance			Date of Completion: 9-10-14		

Facility ID: 00571

If continuation sheet Page 4 of 6

PRINTED: 09/17/2014

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST LUCAS CARE CENTER 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021 FARIBAULT, MN 55021	SURVEY PLETED 26/2014 COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST LUCAS CARE CENTER 500 SOUTHEAST FIRST STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG Continued From page 4 PROVIDENCY OR LSC IDENTIFYING INFORMATION) K 062 K 062 Continued From page 4 K 062 Director (DM) at the time of discovery. K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in K 144	(X5) COMPLETION
ST LUCAS CARE CENTER 500 SOUTHEAST FIRST STREET (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) K 062 Continued From page 4 Director (DM) at the time of discovery. K 144 K 062 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in K 062	
ST LUCAS CARE CENTER FARIBAULT, MN 55021 (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) K 062 Continued From page 4 Director (DM) at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD K 062 K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in K 144	
(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) K 062 Continued From page 4 Director (DM) at the time of discovery. K 144 K 062 K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in K 144	
(X4) ID PREFIX TAG Image: Case of the construction of the co	
K 1002 Oontinued From page 1 Director (DM) at the time of discovery. K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in	
K 144 Director (DM) at the time of discovery. K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in	
Generators are inspected weekly and exercised under load for 30 minutes per month in	
This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. This deficient practice could affect all 77 residentsThe current annual load bank test was completed on 9-17- 2014.	9-17-14
Findings include: Compliance with future required annual load testing due dates will be ensured by	
On facility tour between 9:00 AM and 12:30 PM on 08/26/2014, documentation review of the monthly emergency generator testing logs (September 2013 to August 2014), indicated that the facility did not run the diesel emergency	
generator at 30% of nameplate rating. The facility did not complete the annual load bank test with-in a 12 month period. The 2012 load bank test was done on 11/28/2012 and 2013 was done on 12/26/2013.	
This deficient practice was confirmed by the Date of Completion: 9-17-14	

.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245067	B. WING		08/26/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
K 144	Director (DM) at the	and Facility Maintenance e time of discovery.	K 14	4	
	TEAM COMPOSIT Gary Schroeder, Li	rION fe Safety Code Spc.		4.]	-
				-	
	u.				ţ.
		. '		*	
FORM CMS-25	67(02-99) Prevlous Versions	Obsolete Event ID:0GDf		acility ID: 00571 If contin	uation sheet Page 6 o



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted September 17, 2014

Ms. Jeanine Junker, Administrator Barrett Care Center Inc 800 Spruce Avenue Barrett, Minnesota 56311

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5575024

Dear Ms. Junker:

The above facility was surveyed on September 2, 2014 through September 5, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Barrett Care Center Inc September 17, 2014 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email at: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this eNotice.

Sincerely, Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

5575s14lic