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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0GDF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**
2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
07/27

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. **X** Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 10/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/07/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245067	A. Building B. Wing	10/13/2014

Name of Facility	Street Address, City, State, Zip Code
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, 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	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/07/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0319** Reg. # **483.25(f)(1)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **10/07/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	10/14/2014	18623	10/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/28/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245067	A. Building B. Wing **01 - MAIN BUILDING 01**	10/1/2014

Name of Facility	Street Address, City, State, Zip Code
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0038	**09/25/2014**	ID Prefix Reg. # **NFPA 101** LSC K0062	**09/10/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	**09/17/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 10/14/2014	**Signature of Surveyor:** 25822	**Date:** 10/01/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/26/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0GDF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
07/27

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR-Dietary Specialist 09/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/03/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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;

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

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

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

DEPARTMENT CONTACT

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

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 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

Enclosure

cc: Licensing and Certification File 5067s14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET 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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED SEP 30 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the environment provided an appearance adequate to maintain resident comfort. This had the potential to affect all 39 residents on the first floor unit. In addition, the facility failed to ensure a safe and sanitary environment was provided for 1 of 1 resident (R176) whose bathroom floor was unkempt. Findings include: On 8/28/14, at 10:17 a.m. an environmental tour conducted with the environmental services director (ESD). The following issues were noted in the first floor dayroom and television area:	F 253	1. Corrective action: All cabinetry in question has been removed. A plan for carpet replacement will be in place by 10-7-2014. The soiled incontinence product and bundles wrapped in toilet paper were immediately bagged and removed from the room upon discovery. The bathroom floor of R32 was cleaned immediately upon discovery. Resident R32 was reassessed for urinary incontinence and interventions were care planned and implemented to address refusals of assistance, odors, improperly disposing of soiled toilet paper, and the increased urine frequency.	10-7-14

POC accepted 9/30/14 eStanko

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-29-14

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

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	245067	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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F 253	Continued From page 1 1) Veneer on several cabinets were noted to be chipped and marred. Drill holes and large holes were were visible where old hardware and locks had been removed. One cabinet was missing a door and raw paneling edges were visible, and the cabinet above the refrigerator lacked doors and had holes in the frame. Below the east wall sink, a recess area had exposed water tap and sink drain plumbing, with tubing and pipe visible through broken cinder block. The ill-repaired cabinetry was easily visible to residents using the area. The ESD explained that the area used to be a nursing station, and had been an ongoing project to covert it for resident use. The project was described as a "work in progress," which was subject to funding. The ESD stated the facility had recently hired additional help, and he expected more timely repairs. 2) The carpeting in television room on the first floor was darkened and matted along the edges below the cabinets and the sink along the east wall. The soiled carpet extended around two corners of the room along the bases of the south and west wall cabinets to the refrigerator. Additionally, the carpet directly in front of the television was matted and stained with dark spots. The ESD explained that carpets were cleaned on Wednesdays, with spot cleaning as needed. The carpet had been installed more then 10 years prior, "in the early 90's possibly. We got a couple bids for carpet replacement a couple years ago, but corporate turned it down." A capital request had since been submitted, and although some of the carpeting had been replaced, authorization had not been given for further carpet replacement. The ESD verified the carpet should not have been stained, and he stated it	F 253	2. 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. 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: 10-7-2014	

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F 253	Continued From page 2 would be spot cleaned again that afternoon. The facility's undated Physical Plant--Monthly Inspections directed, "The rooms shall be inspected and any deficiencies shall be documented and scheduled for repair." Bathroom floor: R176's bathroom was observed on 8/25/14, at 4:00 p.m. Observations revealed pervasive urine odors, and two wet, yellow bundles of soiled toilet paper on the floor by the toilet and additional wet and soiled toilet paper and tissues under the sink by the trash can. R176, who shared the bathroom with R32, reported she had once stepped on a wet bundle of toilet paper with her stocking feet. R176 went to the bathroom, opened the door and showed the surveyor the soiled bathroom floor. R176 stated she used the toilet plunger to move the soiled toilet paper and tissues away from the toilet toward the sink. R176 grimaced and stated the bathroom smelled of urine. On 8/25/14, at 5:45 p.m. R32 was interviewed. The pervasive urine odor was again detected in the room. An opened incontinent product was on floor by the bed along with bundles wrapped in toilet paper. R32 explained she did not like to receive help with toileting or bathing, and preferred a bed bath. She changed her soiled incontinent products daily on her own, and self-performed bed baths weekly. At 2:30 p.m. a nursing assistant, (NA)-A, said R32 wrapped up something in toilet paper, but she was unsure what it was she was wrapping. NA-B explained the staff picked up and disposed of items on the floor in R32's room and bathroom periodically throughout the day. NA-A added R32	F 253	4. Recurrence will be prevented by: Random weekly environmental audits will be completed to ensure the facility maintains a sanitary, orderly, and comfortable interior. Random weekly chart audits will be conducted to ensure residents who are found to have urinary incontinence have current bladder assessments and appropriate care planned interventions to ensure they receive the necessary care and services. Additionally, weekly random visual 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 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 Environmental Services and/or designee	

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F 253	Continued From page 3 did refuse help with toileting and incontinence care, and verified a urine odor was present in the resident's room. R32's care plan revised 1/3/14, revealed a problem with stress incontinence of bladder. R32 used an incontinent brief and was independent with changing of the brief. The goal was for R32 to continue self-management. The intervention was to ensure R32 had an adequate supply of incontinent briefs. The care plan also noted the resident preferred to clean up independently by the sink and did not like a whirlpool or shower. The goal was to maintain independence with bathing skills. Interventions were to allow adequate time before offering assistance, clean and trim nails after baths per her preference, and provide towels and soap. On 8/28/14, at 9:00 a.m. the director of nursing (DON) was interviewed. The DON explained that a former staff person was able to get R32 to bathe. They were trying to find another staff person who might be able to deliver care to R32. The DON was unaware of wet toilet paper and bundles in R32's bathroom. She explained they tried to encourage her to accept help with toileting and changing clothing, but the resident was very adamant about what she wanted. The facility did not, however, develop a specific plan for addressing refusals of help, odors, and improperly disposing of soiled toilet paper for R32 to ensure a sanitary environment was maintained for R176.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 4 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively identify adverse side effects and develop non-pharmacological interventions for 2 of 5 residents (R102, R74) reviewed for unnecessary medications. Findings include:	F 278	1. Immediate corrective action: Resident (R102) was comprehensively reassessed for adverse side effects and non-pharmacological interventions. The care plan was updated to include the use of antidepressant medications, monitoring of adverse 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 encouragement of the resident's mood and the objective for the use of the psychoactive medication. The care plan for R 74 was updated to include the use of psychotropic medications and non-pharmacological interventions for sleep. 2. Action as it applies to others: The policy and procedure Writing Care Area Assessment's was reviewed on 9-22-14 and remains current. The policy and procedure for use of Psychopharmacological Medications was reviewed on 9-22-2014 and remains current.	10-7-14

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F 278	Continued From page 5 R102 was observed seated in the common area on 8/27/14, at 9:30 a.m. no behaviors were noted. In addition, was observed seated in the common area on 8/28/14, at 1:00 p.m. no behaviors noted. R102 had Physician's Orders dated 7/28/14, which included bupropion (antidepressant) 300 milligrams (mg) and Celexa (antidepressant) 20 mg. R102's initial Minimum Data Set (MDS) dated 8/4/14, identified diagnoses which included depression. The MDS indicated R102 had received the antidepressant within the last seven days and little or no energy. The resident needs extensive assistance with activities of daily living (ADLs) with one to two staff assist. The medical record had Physician's Progress Notes from Internal medicine dated 8/4/14, which did indicate R102's depression; however, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical did not indicate R102 was under a psychologist care. R102's Care Area Assessment dated 8/8/14, revealed R102 received two antidepressants and had depression. The CAA also indicated R102 expressed a desire to return to the community. The section for unnecessary drug evaluation was left blank which would have indicated R102 received duplicate medications for the same diagnosis. The section for drug related discomfort which would have required treatment and/or prevention was left blank for dehydration, lack of exercise, urinary retention, reduced dietary bulk, constipation/fecal impaction and dry mouth.	F 278	Other residents who receive psychopharmacological medications will be comprehensively reassessed for adverse side effects, non-pharmacological interventions, support and encouragement of the resident's mood and the benefit or necessity of the use of the medication. Licensed nursing staff will be re-educated on the policy for Writing Care Area Assessments. Licensed nursing staff will be re-educated on the policy for the use of Psychoactive Medications. 3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly chart audits will be conducted to ensure residents who receive psychopharmacological medications are comprehensively assessed for adverse side effects, non-pharmacological interventions, support and encouragement of the resident's mood and the benefit or necessity of the use of the medication. 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.	

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F 278	Continued From page 6 However, the Physician's Orders dated 7/28/14, indicated R102 received Colace (stool softener) and as needed bowel suppositories for constipation. In addition, R102 received Lasix (diuretic) daily which would be indicative of adverse side effects dry mouth and dehydration. The CAAs lacked documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same antidepressant class. Even though the facility did monitor the bowel status of R102, the CAAs also lacked evidence of how the facility was going to assess the side effects for the potential risk of dry mouth, constipation and dehydration for the use of the antidepressants. The CAAs did not address how the facility was going to address R102's mood behavior. The CAAs did reveal the facility was to care plan for the depression and medication use. R102's medical record indicated the facility did monitor for adverse side effects of the antidepressants on the Medication Administration Record (MAR) dated 8/1/14 through 8/28/14, however, a thorough assessment had not been completed for the duplicate antidepressant use. R102's care plan printed 8/28/14, was reviewed and the following was noted. The care plan did address the dehydration and constipation, however, the care plan lacked evidence of the antidepressant use, monitoring of adverse effects, the resident's support and encouragement of R102's mood behavior of little energy and being tired, and non-pharmacological interventions. On 8/28/14, at 10:15 a.m. the director of nursing (DON) verified care plan approaches and	F 278	5. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee.	

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F 278	Continued From page 7 non-pharmacological interventions had not been developed for R102. The bupropion Package Insert packaged and distributed by American Health Packaging last revised on 7/8/13, noted the "Bupropion hydrochloride extended-release tablets (XL) can cause serious side effects. Read this entire Medication Guide for more information about these serious side effects. Common side effects reported in studies of major depressive disorder include weight loss, loss of appetite, dry mouth, skin rash, sweating, ringing in the ears, shakiness, stomach pain, agitation, anxiety, dizziness, trouble sleeping, muscle pain, nausea, fast heartbeat, sore throat, and urinating more often. In studies of seasonal affective disorder, common side effects included weight loss, constipation, and gas." The Celexa Package Insert and Label Information by Forest Laboratories, Inc. last revised on 7/14/14, noted the following: "Common possible side effects in people who take Celexa include: nausea, sleepiness, weakness, dizziness, feeling anxious, trouble sleeping, sexual problems, sweating, shaking, not feeling hungry, dry mouth, constipation, diarrhea, respiratory infections, and yawning." R74 was observed walking down the hallway on 8/27/14, at approximately 8:00 a.m. and told a staff person present, "I don't know how I am going to pay for my breakfast." No behaviors were noted during the breakfast meal observation. R74's current received Trazodone HCL	F 278		

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F 278	Continued From page 8 (hydrochloric acid) 100 milligrams (mg) for latent sleep and depression ordered on 1/10/14, Klonopin (anticonvulsant drug) 0.5 mg in the morning and 1 mg in evening ordered for psychotic dementia ordered on 1/11/14, and Risperdal (antipsychotic) 0.25 mg one time a day (QD) for agitation ordered 8/8/14. The medical record had Physician's Progress Notes from Internal Medicine dated 3/31/14, which did indicated R74's Klonopin and Trazodone use and the note revealed "[R74] has been admitted to the nursing. She is no longer in the locked dementia ward and is doing well in the general population of the long term care side of the nursing home. The social worker reports that she feels that [R74] is bored." However, there was no documented clinical rationale for the benefit of, or necessity for, the use of the ordered psychotic medication. The medical did not indicate R74 was under a psychologist care. R74's quarterly Minimum Data Set (MDS) dated 7/15/14, identified diagnoses which included depression. The MDS indicated R74 had received the antidepressant within the last seven days, little or no energy, and had poor appetite or was overeating. The resident needed supervision with dressing, toileting and hygiene and was independent with mobility. R74's Care Area Assessment (CAAs) dated 1/23/14, revealed R74 received antidepressants and had depression. The section for drug related discomfort which would have required treatment and/or prevention was left blank for constipation/fecal impaction. However, the Physician's Orders dated 1/11/14, indicated R74 received Metamucil powder (used to treat	F 278		

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F 278	Continued From page 9 constipation). Even though R74 received antidepressant for sleep, the section for adverse consequences of an antidepressant exhibited by the resident was left blank for insomnia and hallucinations (according to the care plan printed 8/28/14, R74 was being monitored for hallucinations and the Trazodone was ordered for sleep).The CAAs lacked evidence of how the facility was going to assess the side effects for the potential risk of further constipation from the use of the antipsychotic medication and the non-pharmacological interventions for sleep. Also, the CAAs did not address how the facility was going to intervene for R74's mood behavior symptoms regarding little energy, tiredness and poor appetite or overeating. In addition, the facility did not indicate what the overall objective was regarding the psychoactive medication as that section was left blank. Even though the facility did monitor the bowel status of R74, the CAAs lacked evidence of how the facility was going to address the bowel status with regards to the prescribed psychotropic medication. The CAAs did reveal the facility was to care plan for the depression and medication use. On 8/28/14, at approximately 11:45 a.m. the director of nursing (DON) verified R74's care plan did not include the use of psychotropic medications and the non-medication interventions for sleep. The DON stated she would expect the care plan to include this pertinent information and be updated as soon as possible after psychotropic medication was started. The Klonopin Package Insert and Label Information by REMEDYREPACK INC. last revised on 6/3/14, noted the most common side effects of Klonopin included drowsiness,	F 278		

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F 278	Continued From page 10 problems with walking and coordination, dizziness, depression, constipation, fatigue, and problems with memory. The Trazadone Package Insert and Label Information By DIRECT RX last revised 6/10/14 identified the most common side effects of trazodone hydrochloride tablets included sleepiness, dizziness, constipation, and blurry vision The Psychopharmacologic Medication Use policy revised 3/13 indicated, "To assure all non-medication interventions have been attempted to assist with resident's [sic] displaying mood, behavior, or sleep concerns prior to beginning a medication. This policy refers to all neuroleptics, hypnotics, sedatives, antidepressants and anxiolytics. Antipsychotic medication will be used only when it is necessary to treat a specific condition. "The policy also directed staff to monitor and report side effects to the physician as listed in the procedures."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	1. Immediate corrective action: The care plan for Resident (R65) was updated to include: proactive strategies for social adjustment, direction for staff to encourage resident involvement in performing ADL's and decision making and to address: refusal to preform self-care tasks depression, social isolation, anxiety, somatization and resident's behavior towards staff.	10-7-14

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F 279	Continued From page 11 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed for 1 of 1 resident (R65) reviewed for psychosocial adjustment. Findings include: Surveyor: Hakanson, Lisa R65 was observed on 8/27/14, at 8:40 a.m. eating breakfast in bed. She reported she liked remaining in her room because of difficulty walking and nerve pain. She felt she received too many medications, and planned to address the issue with her physician. R65 had been residing in the facility fewer than 60 days. R65's care plan dated 6/3/14 included a focus area that read, "I am adjusting ok to my new environment." The goal was for R65 to continue to express acceptance of current living arrangement. Proactive strategies to address adjustment were not listed, rather staff was to observe for changes in acceptance and intervene as needed. The plan lacked direction for staff as to how they should intervene if problems were noted. The plan also lacked identification of R65's	F 279	2. 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's 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. 3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly resident interview and chart audits will be conducted to ensure residents who display or verbalize mental or psychosocial adjustment difficulty have appropriate care planned interventions and timetables to assist the resident in attaining their highest practicable level of mental and psychosocial well-being.	

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	245067	A. BUILDING _____ B. WING _____	08/28/2014

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F 279	Continued From page 12 refusal to perform self-care, to leave her room, or for depression, anxiety, and somatization. In addition, noted R65 required assistance with dressing, grooming and bathing, with a goal statement, "I want to be well dressed and neatly groomed. I want to participate in my dressing, grooming and bathing." Interventions directed staff to compete the resident's ADLs, but lacked interventions for R65 to work toward independence. It was noted R65 became confused when not feeling well, with a goal for the resident to continue make decisions regarding care and well-being. Interventions were to observe, but lacked other direction for staff related to involving the resident in care and decision making. The plan identified various activities R65 enjoyed. Interventions were to assist the resident with television, radio, provide weekly visits, and encourage to attend groups. It was noted R65 spent most time in her room, and experienced pain with a low tolerance for physical activity. A quality of life focus area identified various activities that R65 enjoyed. The goal was to remind and invite to activities of interest. the interventions were to assist with TV, music, and radio, and to provide weekly contact visits to encourage to attend groups of interest. The Care Area Assessment (CAA) for psychosocial well-being for R65 dated 7/8/14, listed depression, decline in activities of daily living (ADL), mood or behavior problems, heath problems and change in communication as factors that might inhibit social involvement. Documentation by the life enrichment advocate described R65 as having cognitive impairment, psychosocial issues, spent most of her time in bed, and experienced sadness because of her inability to return to her previous living	F 279	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 Director of Nursing and/or designee.	

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F 279	Continued From page 13 arrangement. The CAA indicated psychosocial well-being was to be addressed on R65's care plan. The CAA for psychotropic drug use indicated that R65 was treated with an antidepressant and a hypnotic (to promote sleep). Documentation for the CAA indicated antidepressant and hypnotic medication was used, the resident was newly admitted to the facility, and had diagnoses including somatization disorder (symptoms without real disease), depression, and anxiety. Staff were to observe for side effects and overall effectiveness of medication. The pharmacist was to review medications and the physician would be updated as needed. The CAA indicated psychotropic drug use was to be addressed in R65's care plan. Weekly Medicare review meetings from 7/10/14 to 8/11/14, indicated R65 required extensive assist of two staff with activities of daily living (ADL). R65 was identified as non-compliant with cares, incontinent of bowel and bladder, and required full assistance from staff because she was unwilling to perform self-care. She spent all of her time in the room, often activating the call light and then not remembering why. The 8/15/14, review indicated that although R65 continued to require full assistance from staff, she was becoming more willing to help herself. A subsequent review on 8/21/14, however, noted R65 had been refusing some medications and treatments. On 8/28/14, it was noted R65 spent all of her time in her room only coming out for therapy, and although she was capable of self-care tasks, she was unwilling to do so. R65's initial Minimum Data Set (MDS) assessment dated 7/15/14, indicated R65 was moderately cognitively impaired, but presented no	F 279		

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F 279	Continued From page 14 behavioral issues. She cited daily preferences as being very important and activity preferences being somewhat important. Although she experienced some back pain, she had no impairment in range of motion, but required extensive assistance for ADLs. Two social service assessments were noted in R65's record. On 7/15/14, R65's depression rating was 3, indicative of minimal depression. The comment section indicated R65 was unable to return to her prior living arrangement. A subsequent assessment on 8/7/14, revealed a decline in R65's depression rating at 6, indicative of mild depression. Both assessments lacked a notation of the increase in depressive symptoms, the resident's psychosocial adjustment, negative behavior, refusals of care, or isolation in her room. The general progress notes did not include social service documentation. Nursing notes note dated 8/7/14 and 8/8/14, revealed R65 required assistance of one staff for all transfers, dressing, grooming, toileting and hygiene, and was independent in eating with set up help. She refused to participate in activities and only left her room for therapy. On 8/28/14, at 10:45 a.m. the director of nursing (DON) was interviewed. She explained R65 resisted completing cares she was capable of completing herself, saying it was her right to expect staff to complete them instead. R65 was also known to be "mean and rude" to staff. The DON verified care plan approaches had not been developed to address R65's refusal to perform self-care and to address her behavior toward staff.	F 279		

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F 279	Continued From page 15 The facility's care planning policy dated 8/14, directed staff to ensure individual, resident-centered plans be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay, to promote optimal quality of life. Each resident was to be included in the process and encouraged to achieve or maintain their highest practicable physical and mental abilities.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to help 1 of 1 resident (R32) improve self-care for urinary incontinence. Findings include: R32's bathroom was observed on 8/25/14, at 4:00 p.m. Observations revealed pervasive urine odors, and two wet, yellow bundles of soiled toilet paper on the floor by the toilet and additional wet and soiled toilet paper and tissues under the sink	F 315	1. Immediate corrective action: The soiled incontinence product and bundles wrapped in toilet paper were immediately bagged and removed from the room upon discovery. The bathroom floor was cleansed immediately upon discovery. Resident R32 was reassessed for urinary incontinence and interventions were care planned and implemented to address refusals of assistance, odors, improperly disposing of soiled toilet paper, and the increased urine frequency. 2. Action as it applies to others: 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.	10-7-14

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F 315	Continued From page 16 by the trash can. R176, who shared the bathroom with R32, reported she had once stepped on a wet bundle of toilet paper with her stocking feet. R176 went to the bathroom, opened the door and showed the surveyor the soiled bathroom floor. R176 stated she used the toilet plunger to move the soiled toilet paper and tissues away from the toilet toward the sink. R176 grimaced and stated the bathroom smelled of urine. At 5:45 p.m. R32 was interviewed. The pervasive urine odor was again detected in the room. An opened incontinent product was on floor by the bed along with bundles wrapped in toilet paper. R32 explained she did not like to receive help with toileting or bathing, and preferred a bed bath. She changed her soiled incontinent products daily on her own, and self-performed bed baths weekly. On 8/27/14, at 7:20 a.m. R32 was observed seated in the television area and again a noticeable urine odor was emanating from R32. At 2:30 p.m. a nursing assistant, (NA)-A, said R32 wrapped up something in toilet paper, but she was unsure what it was she was wrapping. NA-B explained the staff picked up and disposed of items on the floor in R32's room and bathroom periodically throughout the day. NA-A added R32 did refuse help with toileting and incontinence care, and verified a urine odor was present in the resident's room. At 2:45 p.m. NA-C explained R32 was very modest and did not wish to receive help with changing her brief or clothes. Staff encouraged her to change clothing each day, but sometimes R32 needed a lot of gentle prodding and	F 315	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. Licensed nursing staff will be re-educated on the policy and procedure for Care Planning. 3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly chart audits will be conducted to ensure residents who are found to have urinary incontinence have current bladder assessments and appropriate care planned interventions to ensure they receive the necessary care and services to aid in maintaining their highest practicable level of well-being. Additionally, Weekly random visual audits will be conducted to ensure staff carry out the plan of care.	

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F 315	Continued From page 17 reminders. NA-C was unsure what R32 wrapped in toilet paper, but made sure the bundles were picked up off the floor, and the resident was reminded to dispose of tissues and toilet paper in the toilet. NA-C said staff also assured R32 the incontinent briefs were free and to change as often as needed. A licensed social worker (LSW)-A was the interviewed at 3:00 p.m. She was unaware R32 was leaving wet toilet paper on the bathroom floor, but was aware she resisted bathing. R32's Care Area Assessment (CAA) dated 9/11/13, for bladder indicated occasional incontinence of urine (type not specified) noted the problem needed to be addressed on the care plan. One modifiable factor of psychological or psychiatric problems was identified, but no other issues or factors were identified as contributing to the problem. Staff was to "monitor." R32's care plan revised 1/3/14, revealed a problem with stress incontinence of bladder. R32 used an incontinent brief and was independent with changing of the brief to manage R32's "dribbling." The goal was for R32 to continue self-management for peri-cares. The intervention was to ensure R32 had an adequate supply of incontinent briefs. The care plan also noted the resident preferred to clean up independently by the sink and did not like a whirlpool or shower. The goal was to maintain independence with bathing skills. Interventions were to allow adequate time before offering assistance, clean and trim nails after baths per her preference, and provide towels and soap. The Minimum Data Set (MDS) dated 6/12/14,	F 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	

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F 315	Continued From page 18	F 315		

indicated R32 was not on a bladder program and was frequently incontinent of urine. In addition, the MDS noted R32 was moderately cognitively impaired. R32's incontinence could not be determined as the CAAs dated 9/11/13, had indicated R32 was occasionally incontinent, the care plan revised on 1/3/14, indicated R32 dribbled, and the MDS dated 6/12/14, indicated R32 was frequently incontinent. R32's was not provided the appropriate services to manage the incontinence.

On 8/28/14, at 9:00 a.m. the director of nursing (DON) was interviewed. She explained they were trying to get a psychological consult for R32 regarding the urine odor and room odor. The DON explained that a former staff person was able to get R32 to bathe. They were trying to find another staff person who might be able to deliver care to R32. R32 had a psychological consult on 8/15/14, after a change in behavior when she was acting in appropriately toward other residents and was attempting to sleep in the chair in the television area at night. The DON was unaware of wet toilet paper and bundles in R32's bathroom. She explained they tried to encourage her to accept help with toileting and changing clothing, but the resident was very adamant about what she wanted. The facility did not, however, develop a specific plan for addressing refusals of help, odors, improperly disposing of soiled toilet paper, and the increased urine frequency.

The facility's 8/14 care planning policy indicated individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay, to promote optimal quality of life. Each resident was to be included in the process and

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F 315	Continued From page 19 encouraged to achieve or maintain their highest practicable physical and mental abilities.	F 315		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure social services was provided for 1 of 1 resident (R65) who displayed psychosocial adjustment issues. Findings include: R65 was observed on 8/27/14, at 8:40 a.m. eating breakfast in bed. She reported she liked remaining in her room because of difficulty walking and nerve pain. She felt she received too many medications, and planned to address the issue with her physician. R65 had been residing in the facility fewer than 60 days. R65's care plan dated 6/3/14 included a focus area that read, "I am adjusting ok to my new environment." The goal was for R65 to continue to express acceptance of current living arrangement. Proactive strategies to address adjustment were not listed, rather, staff was to observe for changes in acceptance and intervene as needed. The plan lacked direction for staff as to how they should intervene if problems were	F 319	1. 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. 2. 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.	10-7-14

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F 319	Continued From page 20 noted. The plan also lacked identification of R65's refusal to perform self-care, to leave her room, or for depression, anxiety, and somatization. In addition, the care plan noted R65 required assistance with dressing, grooming and bathing, with a goal statement, "I want to be well dressed and neatly groomed. I want to participate in my dressing, grooming and bathing." Interventions directed staff to compete the resident's ADLs, but lacked interventions for R65 to work toward independence. It was noted R65 became confused when not feeling well, with a goal for the resident to continue make decisions regarding care and well-being. Interventions were to observe, but lacked other direction for staff related to involving the resident in care and decision making. The plan identified various activities R65 enjoyed. Interventions were to assist the resident with television, radio, provide weekly visits, and encourage to attend groups. It was noted R65 spent most time in her room and experienced pain with a low tolerance for physical activity. A quality of life focus area identified various activities that R65 enjoyed. The goal was to remind and invite to activities of interest. The interventions were to assist with TV, music, and radio, and to provide weekly contact visits to encourage to attend groups of interest. The plan of care lacked evidence of the facility providing interventions that addressed R65's adapting to changes in her life. The Care Area Assessment (CAA) for psychosocial well-being for R65 dated 7/8/14, listed depression, decline in activities of daily living (ADL), mood or behavior problems, heath problems and change in communication as factors that might inhibit social involvement. Documentation by the life enrichment advocate	F 319	3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly resident interview and chart audits will be conducted to ensure residents who display or 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 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.	

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F 319	Continued From page 21 described R65 as having cognitive impairment, psychosocial issues, spent most of her time in bed, and experienced sadness because of her inability to return to her previous living arrangement. The CAA indicated psychosocial well-being was to be addressed on R65's care plan. The CAA for psychotropic drug use indicated that R65 was treated with an antidepressant and a hypnotic (to promote sleep). Documentation for the CAA indicated antidepressant and hypnotic medication was used, the resident was newly admitted to the facility, and had diagnoses including somatization disorder (symptoms without real disease), depression, and anxiety. Staff was to observe for side effects and overall effectiveness of medication. The pharmacist was to review medications and the physician would be updated as needed. The CAA indicated psychotropic drug use was to be addressed in R65's care plan. Weekly Medicare review meetings from 7/10/14 to 8/11/14, indicated R65 required extensive assist of two staff with activities of daily living (ADL). R65 was identified as non-compliant with cares, incontinent of bowel and bladder, and required full assistance from staff to perform self-care. She spent all of her time in the room, often activating the call light and then not remembering why. The 8/15/14, review indicated that although R65 continued to require full assistance from staff, she was becoming more willing to help herself. A subsequent review on 8/21/14, however, noted R65 had been refusing some medications and treatments. On 8/28/14, it was noted R65 spent all of her time in her room only coming out for therapy, and although she was capable of self-care tasks, and she was unwilling to do so.	F 319		

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F 319	Continued From page 22 R65's initial Minimum Data Set (MDS) assessment dated 7/15/14, indicated R65 was moderately cognitively impaired, but presented no behavioral issues. However, the MDS did indicate R65 had mood symptoms of feeling down, depressed and hopeless, had little or no interest in doing things, and feeling tired with no energy two to six days out of the week. She cited daily preferences as being very important and activity preferences being somewhat important. Although she experienced some back pain, she had no impairment in range of motion, but required extensive assistance for ADLs. Two social service assessments were noted in R65's record. On 7/15/14, R65's depression rating was 3, indicative of minimal depression. The comment section indicated R65 was unable to return to her prior living arrangement. A subsequent assessment on 8/7/14, revealed a decline in R65's depression rating at 6, indicative of mild depression. Both assessments lacked a notation of the increase in depressive symptoms, the resident ' s psychosocial adjustment, negative behavior, refusals of care, or isolation in her room. The general progress notes did not include social service documentation. Nursing notes note dated 8/7/14 and 8/8/14, revealed R65 required assistance of one staff for all transfers, dressing, grooming, toileting and hygiene, and was independent in eating with set up help. She refused to participate in activities and only left her room for therapy. On 8/28/14, at 10:45 a.m. the director of nursing (DON) was interviewed. She explained R65 resisted completing cares she was capable of	F 319		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 23 completing herself, saying it was her right to expect staff to complete them instead. R65 was also known to be "mean and rude" to staff. The DON verified care plan approaches had not been developed to address R65's refusal to perform self-care and to address her behavior toward staff. The facility's care planning policy dated 8/14, directed staff to ensure individual, resident-centered plans be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay, to promote optimal quality of life. Each resident was to be included in the process and encouraged to achieve or maintain their highest practicable physical and mental abilities. R65 was not provided care and services to assist her to reach and maintain the highest level of mental and psychosocial functioning.	F 319		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322	1. Immediate corrective action: LPN-A received written counseling for failing to follow facility policy and procedure for Medication Administration though Gastric Tube on 9-23-2014. LPN-A performed a return demonstration for Medication administration through a Gastric Tube on 9-23-2014.	10.7.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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F 322	Continued From page 24 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility protocols for administration of medications through gastrostomy (G-tube) were implemented appropriately for 1 of 1 resident (R16) reviewed for medication administration via G-tube. Findings include: R16's medication administration observation was conducted the morning of 8/27/14, at approximately 8:30 a.m. by a licensed practical nurse (LPN)-A. LPN-A prepared medications for R16 to be administered via a gastric tube (inserted into the stomach to receive medication and/or nutrition). Medications were Baclofen (for muscle spasticity) 10 milligrams (mg), Carbidopa-Levodopa 25-100 mg (for Parkinson's disease), and cranberry tablet (to maintain a healthy urinary tract) 425 mg. The tablets were crushed and mixed together in a small plastic cup with approximately 15 cubic centimeters (ccs) of water. The LPN did flush the tube prior to the administration of the medications. Before the medication administration, the tube feeding was observed to be running and the LPN did not check the residual and placement of the tube prior to the medication administration. LPN-A acknowledged the placement of the tube feeding had been checked at 6:00 a.m. when the tuibe	F 322	2. Action as it applies to others: The policy and procedure for Medication Administration through a Gastric Tube was reviewed on 9-23-2014 and remains current. Licensed nursing staff will be re-educated on the policy for Medication Administration through a Gastric Tube. 3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly visual audits will be conducted to ensure staff remain compliant with facility policy and procedure for Medication Administration thorough a Gastric Tube. 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.	

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F 322	Continued From page 25 feeding had been started. LPN-A then placed a 60 cc syringe on the gastric tube, put the mixed medications into the syringe, and administered the medications through the tube. The tube was then flushed with 15 ccs of tap water. LPN-A verified the medications had been mixed together prior to administration. A nursing note dated 12/31/13, showed R16 had severely impaired cognition and relied on staff for all needs. A diagnostic list dated 8/28/14, revealed R16 had diagnoses which included sclerosis, paralysis agitans (Parkinson's-like) neurogenic bladder, and urinary tract infection. A Medications Review Report dated 8/28/14, directed staff to administer the medications consistent with those administered during the observation and the Medications Review Report did not specify the medications could be administered together. On 8/28/14, at 11:45 a.m. the director of nursing (DON) explained she expected medications to be administered individually, according to the facility policy. The DON verified R16's Physician Orders did not specify medications could be administered together. The facility's written policy, Medication Administration through Gastric Tube revised 2/14, included procedures for G-tube medication administration: "1) e. Each medication should be crushed and administered separately, unless specifically ordered by physician to administer more than one med at a time...8) If feeding is running at time of medication administration, clamp feeding tubing. When separating tube from feeding, insure plug is placed to keep open end clean. 9) Check for residual and placement by	F 322		

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F 322	Continued From page 26 attaching sixty (60) ml (milliliter) piston syringe to gastric tube and gently pulling back no more than 150 ml. a. If meet resistance as aspirate stomach content, stop procedure. b. If no resistance, note amount of residual. Return gastric contents back into stomach. Clamp gastric tube. c. The appearance of gastric content implies that the tube is patent and in the stomach. d., If no gastric content appears, the tube may be against the lining of the stomach or may be obstructed. 10) After establishing that the tube is patent and in correct position, clamp or kink tube. 11) Reattach syringe, without piston, to the end of the tube and open the clamp/unkink the tubing. Flush tube with approximately 15-30 ml water. 12) Administer meds with 5-10 ml water flush in-between medications, or specifically ordered amount per physician. If MD [physician] orders more than one medication administered at a time, specific flush must be included in order. After last medication administered, flush with 15-30 ml warm water. Clamp/plug tube when completed or reattach to feeding. (For resident who requires fluid regulation, the physician's order should include the amount of water to be used for the flushing and in-between meds.)...." LPN-A did not follow the policy regarding checking for the residual and placement of the feeding tube prior to the medication adminsitration. In addition, the LPN did not adminsiter the medications seperately as identified in the policy.	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	1. Immediate corrective action: Resident (R102) was comprehensively reassessed for adverse side effects.	10-7-14

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F 329	Continued From page 27 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify and develop non-pharmacological interventions for 2 of 5 residents (R102, R74) reviewed for unnecessary medications. Findings include: R102 was observed seated in the common area on 8/27/14, at 9:30 a.m. no behaviors were noted. In addition, was observed seated in the common area on 8/28/14, at 1:00 p.m. no behaviors noted. R102 had Physician's Orders dated 7/28/14, which included bupropion (antidepressant) 300	F 329	The care plan for R 102 was updated to include the use of antidepressant medications, monitoring of adverse 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 encouragement of the resident's mood, and the objective for the use of the psychoactive medication. The care plan for R 74 was updated to include the use of psychotropic medications and non-pharmacological interventions for sleep. 2. Action as it applies to others: The policy and procedure for the use of Psychopharmacological Medications was reviewed on 9-22-2014 and remains current. Other residents who receive psychopharmacological medications will be comprehensively reassessed for adverse side effects, non-pharmacological interventions, support and encouragement of the resident's mood and the benefit or necessity of the use of the medication.	

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F 329	Continued From page 28 milligrams (mg) and Celexa (antidepressant) 20 mg. R102's initial Minimum Data Set (MDS) dated 8/4/14, identified diagnoses which included depression. The MDS indicated R102 had received the antidepressant within the last seven days and little or no energy. The resident needs extensive assistance with activities of daily living (ADLs) with one to two staff assist. The medical record had Physician's Progress Notes from Internal medicine dated 8/4/14, which did indicate R102's depression; however, there was no documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class. The medical did not indicate R102 was under a psychologist care. R102's Care Area Assessment dated 8/8/14, revealed R102 received two antidepressants and had depression. The CAA also indicated R102 expressed a desire to return to the community. The section for unnecessary drug evaluation was left blank which would have indicated R102 received duplicate medications for the same diagnosis. The section for drug related discomfort which would have required treatment and/or prevention was left blank for dehydration, lack of exercise, urinary retention, reduced dietary bulk, constipation/fecal impaction and dry mouth. However, the Physician's Orders dated 7/28/14, indicated R102 received Colace (stool softener) and as needed bowel suppositories for constipation. In addition, R102 received Lasix (diuretic) daily which would be indicative of adverse side effects dry mouth and dehydration. The CAAs lacked documented clinical rationale	F 329	Licensed nursing staff and the interdisciplinary team (IDT) will be re-educated on the policy for Psychopharmacological Medication use. 3. Date of completion: 10-7-2014 4. Recurrence will be prevented by: Random weekly chart audits will be conducted to ensure residents who receive psychopharmacological medications are comprehensively assessed for adverse side effects, non-pharmacological interventions, support and encouragement of the resident's mood and the benefit or necessity of the use of the medication. 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.	

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F 329	Continued From page 29 for the benefit of, or necessity for, the use of multiple medications from the same antidepressant class. The CAAs also lacked evidence of how the facility was going to assess the side effects for the potential risk of dry mouth, constipation and dehydration not only by the Lasix but also by the use of the antidepressants. The CAAs did not address how the facility was going to address R102's mood behavior. The CAAs did reveal the facility was to care plan for the depression and medication use. R102's medical record indicated the facility did monitor for adverse side effects of the antidepressants on the Medication Administration Record (MAR) dated 8/1/14 through 8/28/14, however, a thorough assessment had not been completed for the duplicate antidepressant use. R102's care plan printed 8/28/14, was reviewed and the following was noted. The care plan did address the dehydration and constipation, however, the care plan lacked evidence of the antidepressant use, monitoring of adverse effects, the resident's support and encouragement of R102's mood behavior of little energy and being tired, and non-pharmacological interventions. On 8/28/14, at 10:15 a.m. the director of nursing (DON) verified care plan approaches and non-pharmacological interventions had not been developed for R102. The bupropion Package Insert packaged and distributed by American Health Packaging last revised on 7/8/13, noted the "Bupropion hydrochloride extended-release tablets (XL) can cause serious side effects. Read this entire	F 329		

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F 329	Continued From page 30 Medication Guide for more information about these serious side effects. Common side effects reported in studies of major depressive disorder include weight loss, loss of appetite, dry mouth, skin rash, sweating, ringing in the ears, shakiness, stomach pain, agitation, anxiety, dizziness, trouble sleeping, muscle pain, nausea, fast heartbeat, sore throat, and urinating more often. In studies of seasonal affective disorder, common side effects included weight loss, constipation, and gas." The Celexa Package Insert and Label Information by Forest Laboratories, Inc. last revised on 7/14/14, noted the following: "Common possible side effects in people who take Celexa include: nausea, sleepiness, weakness, dizziness, feeling anxious, trouble sleeping, sexual problems, sweating, shaking, not feeling hungry, dry mouth, constipation, diarrhea, respiratory infections, and yawning." R74 was observed walking down the hallway on 8/27/14, at approximately 8:00 a.m. and told a staff person present, "I don't know how I am going to pay for my breakfast." No behaviors were noted during the breakfast meal observation. R74's current received Trazodone HCL (hydrochloric acid) 100 milligrams (mg) for latent sleep and depression ordered on 1/10/14, Klonopin (anticonvulsant drug) 0.5 mg in the morning and 1 mg in evening ordered for psychotic dementia ordered on 1/11/14, and Risperdal (antipsychotic) 0.25 mg one time a day (QD) for agitation ordered 8/8/14.	F 329		

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F 329	Continued From page 31 The medical record had Physician's Progress Notes from Internal medicine dated 3/31/14, which did indicated R74's Klonopin and Trazodone use and the note revealed "[R74] has been admitted to the nursing. She is no longer in the locked dementia ward and is doing well in the general population of the long term care side of the nursing home. The social worker reports that she feels that [R74] is bored." However, there was no documented clinical rationale for the benefit of, or necessity for, the use of the ordered psychotic medication. The medical did not indicate R74 was under a psychologist care. R73s quarterly Minimum Data Set (MDS) dated 7/15/14, identified diagnoses which included depression. The MDS indicated R74 had received the antidepressant within the last seven days and little or no energy and had poor appetite or was overeating. The resident needed supervision with dressing, toileting and hygiene and was independent with mobility. R74's Care Area Assessment (CAAs) dated 1/23/14, revealed R74 received antidepressants and had depression. The section for drug related discomfort which would have required treatment and/or prevention was left blank for constipation/fecal impaction. However, the Physician's Orders dated 1/11/14, indicated R74 received Metamucil powder (used to treat constipation). Even though R74 received antidepressant for sleep the section for adverse consequences of an antidepressant exhibited by the resident was left blank for insomnia and hallucinations (according to the care plan printed 8/28/14, R74 was being monitored for hallucinations and the Trazodone was ordered for	F 329		

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F 329	Continued From page 32 sleep). The care plan for R74 revised 5/06/14 directs staff to monitor for confusion and other signs of delerium and further evaluate and to attempt to redirect and assure no one is trying to taken her belongings or talk about her. The CAAs lacked evidence of how the facility was going to assess the side effects for the potential risk of further constipation from the use of the antipsychotic medication and the non-pharmacological interventions for sleep. Also, the CAAs did not address how the facility was going to intervene for R74's mood behavior symptoms regarding little energy, tiredness and poor appetite or overeating. In addition, the facility did not indicate what the overall objective for was regarding the psychoactive medication as that section was left blank. The CAAs did reveal the facility was to care plan for the depression and medication use. R74's care plan printed 8/28/14, was reviewed. The care plan did not address the further potential risk of the adverse effect of constipation from the psychotropic drug use, and use of non-pharmaceutical interventions for sleep. On 8/28/14, at approximately 11:45 a.m. the director of nursing (DON) verified R74's care plan did not include the use of psychotropic medications, non-medication interventions for sleep. The DON stated she would expect the care plan to include that information and be updated as soon as possible after psychotropic medication was started. The Klonopin Package Insert and Label Information by REMEDYREPACK INC. last revised: 6/3/14, noted the most common side effects of Klonopin included drowsiness,	F 329		

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F 329	Continued From page 33 problems with walking and coordination, dizziness, depression, constipation, fatigue, and problems with memory. The Trazadone Package Insert and Label Information By DIRECT RX last revised 6/10/14, identified the most common side effects of trazodone hydrochloride tablets included sleepiness, dizziness, constipation, and blurry vision The Psychopharmacologic Medication Use policy revised 3/13, indicated, "To assure all non-medication interventions have been attempted to assist with resident's [sic] displaying mood, behavior, or sleep concerns prior to beginning a medication. This policy refers to all neuroleptics, hypnotics, sedatives, antidepressants and anxiolytics. Antipsychotic medication will be used only when it is necessary to treat a specific condition. "The policy also directed staff to monitor and report side effects to the physician as listed in the procedures."	F 329		

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

F5067022

PRINTED: 09/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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	K 000	POC ok TS 9-30-14 RECEIVED SEP 29 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 10-7-14
EXIT: 8-28-14

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

TITLE: Administrator

(X6) DATE: 9-29-14

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET 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)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Lucas Care Center was constructed at 5 different times.. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor are used for health care). In 1960 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and the 4 additions and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 . The deficient practice could affect all 15 out of 77 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 08/26/2014, observation revealed, that the 90 wing required exit discharge has more than 1/2" elevation change at top landing area and at the bottom of steps at public way. This deficient practice was confirmed by the	K 038	The exit discharge elevation in question has been leveled and is now compliant. Other exit discharge elevations were inspected and are compliant. 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 Environmental Services and/or designee Date of Completion: 09-25-14	9-25-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 038	Continued From page 3 Administrator (JA) and Facility Maintenance Director (DM) at the time of discovery.	K 038		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 9-4.2.1 and 10-2.2. This deficient practice could affect all 77 residents Findings include: On facility tour between 9:00 AM and 12:30 PM on 08/26/2014, a review of the Olympic annual fire sprinkler inspection records dated 10/16/2013 indicated the following: 1. There was no 5 year internal inspection of the check valves 2. There was no 5 year internal inspection of the system pipes There was no documentation stating the above has been corrected. These deficient practices were confirmed by the Administrator (JA) and Facility Maintenance	K 062	The 5-year internal inspections of the check valves was completed on 9-10-2014. The 5-year internal inspection of the system pipes was completed on 9-10-2014. Future ongoing 5-year inspection due dates will be determined based on the previous inspection dates listed on the Fire Marshall's recommended Annual Inspection form. Ongoing compliance will be monitored by the Director of Environmental Services and/or designee Date of Completion: 9-10-14	9-10-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 4 Director (DM) at the time of discovery.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 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 residents Findings include: 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	K 144	The current annual load bank test was completed on 9-17-2014. Compliance with future required annual load testing due dates will be ensured by placement of a visual reminder of the next due date on the generator transfer switch which is visualized during monthly load testing. Ongoing compliance will be monitored by the Director of Environmental Services and/or designee. Date of Completion: 9-17-14	9-17-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 5 Administrator (JA) and Facility Maintenance Director (DM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

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 only a suggestion 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.

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
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