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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 307W

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.IATEIOFISURVEY **8/14/2017** (L34)

8. ACCREIITATIONISTATUS ___ (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 **90** (L18)
13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B.IIINotIinICmplianceIwithIProgram 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
	90			
(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 :
Susie Haben, Unit Supervisor 8/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 8/23/2017 (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
08/04/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245067 August 23, 2017

Mr. Joseph Gubbels, Administrator
St. Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

Dear Mr. Gubbels:

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 July 22, 2017 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2017

Mr. Joseph Gubbels, Administrator
St. Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067028

Dear Mr. Gubbels:

On June 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 24, 2017 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 June 8, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2017, effective July 22, 2017 and therefore remedies outlined in our letter to you dated June 20, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 307W

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(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 **06/08/2017** (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

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___1. Acceptable POC
X B. 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 07/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/04/2017 (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
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3. Both of the Above :

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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
08/04/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 22, 2017

Mr. Joseph Gubbels, Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067028

Dear Mr. Gubbels:

On June 8, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS 2567, whereby corrections are required.

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:

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

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - 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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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 July 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 8, 2017 (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 December 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

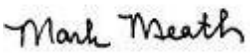
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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 _____	06/08/2017

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 On June 5, 6, 7 and 8th, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		7/22/17

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

Electronically Signed | 06/29/2017

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 _____	06/08/2017

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 309	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate hospice care for 1 of 1 resident (R6) reviewed who recieved hospice services. Findings include: R6's family member (FM)-D on 6/6/17, at 10:31 a.m. stated R6 recently transitioned to hospice care as she had experienced a decline in her condition in the past few months. On 6/7/17, at 1:21 p.m. a hospice nursing assistant (HNA)-A stated hospice provided personal cares and showers for R6. She explained a HNA came two times per week on Wednesdays and Fridays. HNA-A stated she did	F 309	F309 Immediate corrective action: Resident #6 Care Plan was updated on __6/20/17_____(date)to include all the services and visit days provided by Hospice. Action as it applies to others: All residents receiving Hospice services will have their Care Plan reviewed to assure the integration of services and days of visits are clearly identified. All nursing staff will be inserviced on _7/11/17_____(date) to review the template on the I Care Plan under Special Services which includes the Integration of Hospice Services. Date of completion:	

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 _____	06/08/2017

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 309	Continued From page 2 not shower R6 on Wednesdays because the facility gave her showers that day. She further stated she thought the HNA who visited on Fridays would offer a shower for R6 but did not know for sure. During interview on 6/8/17, at 1:06 p.m. nursing assistant (NA)-B stated it was confusing to know how cares for R6 were coordinated with hospice. She stated there was not a hospice care schedule for R6. NA-B stated Wednesdays were normal bath days for R6. However, she had noticed when a HNA visited R6 they did not shower her so the facility usually ended up doing the shower. NA-B confirmed it takes two people to transfer R6 to the shower chair and one person to assist her with shower. On 6/8/17, at 1:13 p.m. NA-A stated she was unsure of the current hospice schedule of visits for R6. She explained the NAs have a shower sheet chart for each resident and R6's shower day was listed as Wednesday. NA-A stated when a HNA came to visit R6 on a Wednesday, the HNA did not shower R6. During interview on 6/8/17 at 1:29 p.m., the director of nursing (DON) stated the hospice visit schedule was in the hospice binder for R6. She expected NAs to look in R6's hospice chart to find the hospice visit schedule. She further stated the facility NAs should be providing showers for R6 in addition to any showers provided by hospice. At 1:45 p.m., the DON called licensed practical nurse (LPN)-C who was assigned to care for R6 on 6/7/17 (R6's scheduled shower day). LPN-C stated she was told a HNA was visiting R6 on 6/7/17 and stated she expected the HNA to give R6 a shower however, acknowledged she had	F 309	___7/22/17_____ Recurrence will be prevented by: An Audit of all Hospice Care Plans will be completed weekly x 90 days to assure any updates or changes have been clearly identified in the Resident Care Plan. The results of the Audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/MDS Coordinators	

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	245067	A. BUILDING _____ B. WING _____	06/08/2017

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F 309	Continued From page 3 not confirmed whether R6 had been given a shower. Review of R6's review revealed R6 had been admitted to hospice on 5/2/17, with an admitting diagnosis of Alzheimer's disease. A care plan for R6 dated 12/22/16, indicated dressing/grooming/bathing as a focus. Interventions included, "I need extensive assist of 1 staff with my dressing, grooming and bathing." Another care plan problem dated 4/24/17, indicated hospice as a focus. Interventions included: "Responsibility for aspects of my care will be defined between the facility and the Hospice provider and shared with all staff providing care for me, using the facility care plan and NA tool." A 2/2014 facility policy titled Hospice Program was provided. The policy indicated there was to be identification of the specific services that would be provided by each entity, and indicated the information would be communicated in the resident's plan of care.	F 309		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		7/22/17

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F 334	Continued From page 4	F 334		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

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F 334	Continued From page 5 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their policies were implemented to ensure 1 of 5 residents (R12) was offered appropriate pneumococcal vaccine in accordance with current recommendations. Findings include: The current guidelines by the Center for Disease Control and Prevention (CDC) include: "Adults 65 years of age or older who have not previously received PPSV23 [pneumococcal polysaccharide vaccine 23] and who have previously received one or more doses of PCV13 [Pneumococcal Conjugate Vaccine] should receive a dose of PPSV23. The dose of PPSV23 should be given at least 1 year after receipt of the most recent PCV13 dose." R12's record was reviewed. The admission facesheet indicated R12 was 95 years old. Review of the facility supplied Immunization Report run 6/8/17, identified R12 received the	F 334	F334 Immediate corrective action: Resident #12 was offered the PPSV23 on __6/17/17_____(date) and _accepted_____(refused or accepted). Action as it applies to others: The Policy and Procedure on Immunizations was reviewed and remains current. All residents will be reviewed to assure they have been offered the opportunity for the necessary and indicated immunizations, to include the PPSV23, and a sustainable ongoing tracking plan will be put into place. Date of completion: __7/22/17_____ Recurrence will be prevented by: Each week, a list will be maintained by the Infection Control Nurse and audited by the DON/Designee to assure all appropriate immunizations are being offered. This will	

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F 334	Continued From page 6 PCV13 in 2015, however had no documented evidence the PPSV23 had been offered, refused or administered. On 6/8/17, at 3:16 p.m. the director of nursing and assistant director of nursing stated that within the last year residents had not been offered the PPSV23, and that there was no system in place at this time to offer and complete PPSV23 vaccinations. The facility's "Pneumococcal Vaccination-Resident/Patient" policy dated November 2016, indicated that all residents would be offered and encouraged to receive the pneumococcal vaccine. The policy also indicated, adults aged 65 or older "should receive a single dose of PCV13 followed by a dose of PPSV23, 12 months after the PCV13 vaccination was administered."	F 334	continue x 90 days and the results shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Infection Control/DON	
F 431 SS=B	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 431		7/22/17

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F 431	Continued From page 7 employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff	F 431	F431 Immediate corrective action:	

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F 431	Continued From page 8 implemented facility protocols to ensure accurate reconciliation of narcotic medications for 1 of 1 discharged residents from the Sheltering Arms unit (R150) who had utilized a narcotic medication. Findings include: During observation of a medication cart in the Sheltering Arms unit on 6/7/17 at 8:50 a.m., it was noted there was a bottle of liquid hydromorphone medication in the cart. The medication label indicated the narcotic medication had been prescribed for R150. At that time, the narcotic count book was reviewed with licensed practical nurse (LPN)-A and it was determined the medication had been discontinued on 5/18/17. Further review of R150's closed record revealed the resident had discharged from the facility to another setting on 5/24/17. At the time of the medication cart observation LPN-A stated, "I have not counted this medication because it was discontinued. When a medication is discontinued we do not count them on this floor. I don't know what the facility policy says about counting discontinued medication." During an interview with the director of nursing (DON) at 1:50 p.m. on 6/7/17, the DON stated the nurses should be notifying her when medications are discontinued. The DON further stated discontinued medications should be counted per facility policy until they are destroyed. The DON stated, "Yes it should be counted every shift as long as it is in the cart." LPN-A, present at the time of this interview stated, "I did not know discontinued medications need to be counted." The policy provided by the facility dated June	F 431	LPN A was provided education on the Counting and Destruction of Narcotics on __6/12/17_____(date). The Liquid Hydromorphone prescribed to resident for R150 was destroyed on ___6/7/17_____(date). Action as it applies to others: All med carts were inspected to ensure all medications needing counted are being counted. All licensed nurses and TMA□s were educated on the Counting and Destruction of Narcotics on ___6/11/17_____(date). Date of completion: Recurrence will be prevented by: Audits of all med carts we be completed weekly x 4 weeks, then monthly x 2 to assure the policy on Counting and Destruction of Narcotics is being followed. Results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Staff Development	

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F 431	Continued From page 9 2016, titled Narcotics--Counting and Destruction indicated: "Policy- To provide accurate regualtion and maintenance of controlled substances. All schedule 1 thorough 4 controlled substances are to be counted and use monitored...Discontinuance/Destruction: 1) Chart on the Disposal of med form in teh resident/patient chart and the narcotic book...bring to DON office for destruction."	F 431		

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K 000	INITIAL COMMENTS	K 000		

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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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

By email to:
Marian.Whitney@state.mn.us and

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 90 beds and had a census of 86 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=D	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 06/06/2017, based on observation and interview revealed that the following include: The exit sign located in 1st floor north wing (70 units) can not be seen from both side of corridor. This deficient practice could affect the safety of all	K 293	K-293 Immediate corrective action: A 2 sided exit sign will be ordered, and installed by a licensed electrician by July, 22, 2017 Action as it applies to others: The Administrator and maintenance director will inspect the sign to ensure compliance . Date of completion: July, 22,2017 Recurrence will be prevented by: All exit signs will be inspected during monthly rounds by maint. team to ensure continued compliance. The correction will be monitored by: Adm. and Maint. director	7/22/17

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K 293	Continued From page 3 the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 293		
K 362 SS=D	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is not met as evidenced by: Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above	K 362	K-362 Immediate corrective action: The penetration through the fire wall assembly above the doors in the hallway between the north wing and old hospital has been sealed with mineral wool and a respected fire caulking. Action as it applies to others:	7/22/17

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K 362	Continued From page 4 the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating B if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 06/06/2017, based on observation and interview revealed that the following include: Found a penetration through the fire wall assembly above the doors in the hallway between the north wing and old hospital. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 362	This will be completed by the maintenance director by 7/22/17. Date of completion: July, 22,2017 Recurrence will be prevented by: The adm. and maint. director will complete rounds to ensure compliance to all areas of the facility. The correction will be monitored by: Adm. and Maint. director	
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least	K 363		7/22/17

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	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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
K 363	Continued From page 5 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed.	K 363	K-363 Immediate corrective action: The bottom door strikes on the fire doors by the front desk between the long term care and TCU will be secured in the floor per door manufactures recommendation and specifications. This work will be completed by the maint. director. Action as it applies to others: The Administrator and maintenance	

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	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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K 363	Continued From page 6 There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 06/06/2017, based on observation and interview revealed that the following included: The fire doors do not latch at the bottom located in the TCU unit by the front desk. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	director will inspect the door strikes to ensure compliance . Date of completion: July, 22,2017 Recurrence will be prevented by: The adm. and maint. director will complete rounds to ensure compliance to all areas of the facility. The correction will be monitored by: Adm. and Maint. director	

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K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 06/06/2017, based on observation and interview revealed that the following include: A penetration in smoke barrier located on 2nd floor by room 215.	K 372	K-372 Immediate corrective action: The penetration in smoke barrier located on 2nd floor by room 215 has been sealed with mineral wool and respected/approved fire caulk. This will be completed by the maint. director Action as it applies to others: The Administrator and maintenance director will inspect the caulking and seal to ensure compliance . Date of completion: July, 22,2017 Recurrence will be prevented by: The adm. and maint. director will complete rounds to ensure compliance to all areas of the facility. The correction will be monitored by: Adm. and Maint. director	7/22/17

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K 372	Continued From page 8 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 22, 2017

Mr. Joseph Gubbels, Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5067028

Dear Mr. Gubbels:

The above facility was surveyed on June 5, 2017 through June 8, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the

statement, "This MN Requirement 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 Maria King at (507) 344-2716 or email: maria.king@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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00571	A. BUILDING: _____ B. WING _____	06/08/2017

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ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On June 5, 6, 7 and 8, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate hospice care for 1 of 1 resident (R6) reviewed who recieved hospice services. Findings include: R6's family member (FM)-D on 6/6/17, at 10:31 a.m. stated R6 recently transitioned to hospice care as she had experienced a decline in her condition in the past few months. On 6/7/17, at 1:21 p.m. a hospice nursing assistant (HNA)-A stated hospice provided	2 830	Immediate corrective action: Resident #6 Care Plan was updated on __6/20/17_____(date)to include all the services and visit days provided by Hospice. Action as it applies to others: All residents receiving Hospice services will have their Care Plan reviewed to assure the integration of services and days of visits are clearly identified. All nursing staff will be inserviced on _7/11/17_____(date) to review the template on the I Care Plan under Special Services which includes the Integration of	6/29/17

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2 830	Continued From page 3 personal cares and showers for R6. She explained a HNA came two times per week on Wednesdays and Fridays. HNA-A stated she did not shower R6 on Wednesdays because the facility gave her showers that day. She further stated she thought the HNA who visited on Fridays would offer a shower for R6 but did not know for sure. During interview on 6/8/17, at 1:06 p.m. nursing assistant (NA)-B stated it was confusing to know how cares for R6 were coordinated with hospice. She stated there was not a hospice care schedule for R6. NA-B stated Wednesdays were normal bath days for R6. However, she had noticed when a HNA visited R6 they did not shower her so the facility usually ended up doing the shower. NA-B confirmed it takes two people to transfer R6 to the shower chair and one person to assist her with shower. On 6/8/17, at 1:13 p.m. NA-A stated she was unsure of the current hospice schedule of visits for R6. She explained the NAs have a shower sheet chart for each resident and R6's shower day was listed as Wednesday. NA-A stated when a HNA came to visit R6 on a Wednesday, the HNA did not shower R6. During interview on 6/8/17 at 1:29 p.m., the director of nursing (DON) stated the hospice visit schedule was in the hospice binder for R6. She expected NAs to look in R6's hospice chart to find the hospice visit schedule. She further stated the facility NAs should be providing showers for R6 in addition to any showers provided by hospice. At 1:45 p.m., the DON called licensed practical nurse (LPN)-C who was assigned to care for R6 on 6/7/17 (R6's scheduled shower day). LPN-C stated she was told a HNA was visiting R6 on	2 830	Hospice Services. Date of completion: ___7/22/17_____ Recurrence will be prevented by: An Audit of all Hospice Care Plans will be completed weekly x 90 days to assure any updates or changes have been clearly identified in the Resident Care Plan. The results of the Audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/MDS Coordinators	

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2 830	Continued From page 4 6/7/17 and stated she expected the HNA to give R6 a shower however, acknowledged she had not confirmed whether R6 had been given a shower. Review of R6's review revealed R6 had been admitted to hospice on 5/2/17, with an admitting diagnosis of Alzheimer's disease. A care plan for R6 dated 12/22/16, indicated dressing/grooming/bathing as a focus. Interventions included, "I need extensive assist of 1 staff with my dressing, grooming and bathing." Another care plan problem dated 4/24/17, indicated hospice as a focus. Interventions included: "Responsibility for aspects of my care will be defined between the facility and the Hospice provider and shared with all staff providing care for me, using the facility care plan and NA tool." A 2/2014 facility policy titled Hospice Program was provided. The policy indicated there was to be identification of the specific services that would be provided by each entity, and indicated the information would be communicated in the resident's plan of care. Suggested Method of Correction: The director of nursing or designee could review policy and procedures regarding nursing care coordination with the contracted Hospice provider. The director of nursing/designee could ensure staff education to the policies and procedures, and could develop a monitoring a system to ensure compliance. Audits could be completed and reported to the Quality committee. Time Period for Correction: Twenty-one (21) days.	2 830		

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21426	Continued From page 5	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide tuberculosis (TB) screening in accordance with State guidelines for 4 of 5 residents (R6, R69, R152, R177) and 2 of 5 employees (NA (nursing assistant)-C, RN (registered nurse)-B). Findings include: Review of nursing assistant (NA)-C's personnel file revealed a hire date of 3/27/17. There was no	21426	State licensing order 2830- Refer to POC F309 for correction. State Licensing order 21426 Immediate corrective action: Residents # 6, 69, 152, 177 and NAR C and RN B were administered the TB Skin tests and symptom screen per policy. Action as it applies to others: The Policy and Procedure on Immunizations was reviewed and remains	6/29/17

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21426	Continued From page 6 documented record of NA-C having had a tuberculin skin test (TST) or blood test. Registered nurse (RN)-B's personnel file revealed a hire date of 4/27/17. There was no documented TB symptom screen documented upon hire, or was there a second step TST documented. R69 admission face sheet indicated an admission date of 1/25/17. Record review indicated an undated and incomplete TB Screen for R69. R152 admission face sheet indicated an admission date of 2/3/17. Record review indicated an undated and incomplete TB Screen for R152. R177 admission face sheet indicated an admission date of 5/12/17. Record review indicated no TB symptom screen had been completed. R6 admission face sheet indicated an admission date of 5/17/16. Record review indicated no TB symptom screen had been completed. In addition, the record indicated a first step TST was not completed until 11/3/16. During interview on 6/8/17, at 3:03 p.m. the director of nursing (DON) confirmed there was no documentation indicating complete TST testing had been conducted for NA-C or RN-B. The DON further stated there was no documentation indicating TB symptom screens had been completed for R69, R152, R177 or R6 within 72 hours of admission. The DON explained she expected all employees and residents to be screened and tested for TB according to the facility policy.	21426	current. All residents and staff records will be reviewed to assure all are current with TB Skin tests per policy. Date of completion: 6/29/17 Recurrence will be prevented by: Each week, a list will be maintained by the Infection Control Nurse and audited by the DON/Designee to assure all appropriate TB Skin tests, symptom assessment, second step skin tests are being offered per policy. This will continue x 90 days and the results shared with the facility QAPI for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Infection Control/DON	

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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) COMPLETE DATE
21426	Continued From page 7 A facility policy dated July 2014, titled TUBERCULOSIS PREVENTION & CONTROL PROGRAM was provided. The policy included: "A resident's clinical record must contain a report of a tuberculin test within (3) three months prior to admission or within 72 hours after admission." It further indicated "all health care workers and volunteers of the facility will be tested prior to employment or volunteering." Suggested Method of Correction: The director of nursing or designee could review their policies and procedures regarding tuberculin screening/testing. The director of nursing/designee could educate staff on policies and procedures and could develop a monitoring system to ensure compliance. Audits could be completed and reported to the Quality committee. Time Period for Correction: Twenty-one (21) days.	21426		