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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3TU0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245407**

2.STATE VENDOR OR MEDICAID NO.
(L2) **346740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

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 **05/28/2014** (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)
09/30

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

12.Total Facility Beds **95** (L18)

13.Total Certified Beds **95** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(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):
CCN-24-5407

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 3, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/18/2014 (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
11/01/1988
(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
05/20/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245407

June 16, 2014

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, Minnesota 56087

Dear Mr. Jensen:

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 June 2, 2014 the above facility is certified for:

95 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 4, 2014

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, Minnesota 56087

RE: Project Number S5407022

Dear Mr. Jensen:

On April 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 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 May 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 3, 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 April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective June 2, 2014 and therefore remedies outlined in our letter to you dated April 14, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245407	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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 **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **05/12/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **05/12/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/12/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/12/2014**	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	06/04/2014	03048	05/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/3/2014

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
245407	A. Building B. Wing **01 - MAIN BUILDING 01**	6/3/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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	Correction Completed **05/12/2014**	ID Prefix	Correction Completed **05/12/2014**	ID Prefix	Correction Completed **06/02/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0029		LSC K0038	
ID Prefix	Correction Completed **05/12/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	06/04/2014	25822	06/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/2/2014

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: 3TU0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245407**
2.STATE VENDOR OR MEDICAID NO.
(L2) **346740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

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 **04/03/2014** (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)
09/30

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

12.Total Facility Beds **95** (L18)

13.Total Certified Beds **95** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 04/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2014 (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
11/01/1988
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

24-5407

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 14, 2014

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, Minnesota 56087

RE: Project Number S547022

Dear Mr. Jensen:

On April 3, 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:

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Office: (507) 537-7158 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 13, 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 May 13, 2014 the following remedy will be imposed:

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

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.

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 July 3, 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 October 3, 2014 (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 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 electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the 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	F 278	EPOC	5/12/14

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

Electronically Signed | 04/18/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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 278	Continued From page 1 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 interview and document review the facility failed to accurately code the Minimum Data Set (MDS) assessment related to prognosis for 1 of 3 residents (R102) reviewed for weight loss. Findings include: R102's record was reviewed. Physician admission orders to RAH (Redwood Area Hospital) Hospice dated 1/23/14 included a terminal diagnosis, prostate cancer with mets (metastases) to the lung. The record further revealed a Certification of Terminal Illness Statement form signed by the physician on 1/27/14, which included the following statement: "I certify that this patient is terminally ill, with a life expectancy of six months or less if the disease follows its normal course." The significant change MDS dated 2/1/14, indicated R102's diagnoses included malignant neoplasm of the prostate. However, the MDS documentation indicated that R102 did not have a condition that may result in a life expectancy of less than six months. During interview on 4/2/14, at 5:08 p.m. registered nurse (RN)-B confirmed the 2/1/14	F 278	SJLH will continue to ensure that all resident's assessments including R# 102 will be accurate and reflect the resident's current status Resident # 102's MDS has been corrected and resubmitted, and now currently reflects his prognosis on the 2-1-14 MDS. All residents in the facility are at risk for inaccurate coding of MDS assessments All interdisciplinary team members who complete a portion of the MDS will be re-inserviced on the importance of coding the assessment accurately including the current prognosis. The accuracy of coding on the MDS will be monitored by conducting audits of 25% of all MDS's completed each week. Results of the audits will be shared with the interdisiplinary weekly and with the QA & A commmittee quarterly. Audits will continue until the QA & A committee no longer deems necessary.	

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F 278	Continued From page 2 MDS did not accurately reflect R102's current prognosis.	F 278		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medication was administered without error for 2 of 29 medication opportunities affecting one (1) resident (R76). The medication error rate was 7%. Findings include: During observation on 4/3/14, at 7:55 a.m. trained medication aide (TMA)-A was noted to set up morning medications for R76. TMA-A removed one Cranberry 6000 milligram (mg) tablet from the bottle and placed it into a paper medicine cup. TMA-A also removed one Calcium 500 mg + Vitamin D3 200 international units (IU) tablet from the bottle and placed into the same paper cup. TMA-A was observed to administer the medication to R76. During review of R76's medical record, it was noted the physician's orders were as follows: Cranberry (1) tablet 450 mg by mouth daily and one tablet of Calcium 500 mg + Vitamin D3 400 IU by mouth twice daily. After inspection of the medication bottles on 4/3/14, at 8:00 a.m. TMA-A and registered nurse (RN)-C verified the dosage	F 332	St. John Lutheran Home will continue to ensure medications are administered to all residents in the facility including Resident #76 with an error rate of 5% or less. REGARDING CITED FINDINGS: The physician orders for resident #76 have been clarified and the MAR and medication labels now match. IDENTIFYING OTHER RESIDENTS: All residents in the facility are at risk for medication errors. CORRECTIVE MEASURES: All licensed nurses and trained medication aides who pass medications will be re-inserviced on the policy and procedure for checking in new medications received from the pharmacy and on the oral medication procedure including checking the MAR and the medication label three times, and what to do if the MAR and label do not agree.	5/12/14

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F 332	Continued From page 3 on the bottles (Cranberry 6000 mg & Vitamin D3 200 IU) did not match the current physician's orders (Cranberry 450 mg & Vitamin D3 400 IU). On 4/3/14, at 8:25 a.m. RN-C stated the evening nurse routinely verifies the medications ordered from the pharmacy match the current physician order. RN-C also verified that the person administering the medication should be comparing the medication label with the medication administration record (MAR) to ensure proper dosing. When interviewed on 4/3/14, at 8:40 a.m. the director of nursing (DON) also verified the evening nurse is responsible to ensure the medications delivered match the current physician order. In addition, the DON stated the expectation for staff administering medications, would be to verify that the medication label matched the MAR. If a discrepancy is noted, staff are to report to the charge nurse. After review of R76's physician orders on 4/3/14, at 9:00 a.m. the DON verified the dosage discrepancy. An undated policy, Receipt of Medication into the Facility, indicated: the charge nurse shall visually inspect each mediation delivered to the facility. The visual inspection shall insure correct medication and dose, correct packaging and amount and correct labeling. The facility's Oral Medication policy dated 11/2005 instructed staff to (1) read each order entirely, (2) read the label three times and (3) if there is any discrepancy between the medication record and the label, nurse to check physician	F 332	MONITORING: Medication pass audits will be done at random 4 times a week for two weeks then 2 times a week for two weeks. Then as necessary as determined by the QA & A committee. The results of the med pass audits will be reported to the pharmacy consultant monthly and the QA&A committee quarterly. The Director of Nursing and RN supervisors will be responsible for maintaining compliance.	

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F 332	Continued From page 4 orders before administering medication.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain kitchen equipment (meat slicer and can openers) in a clean and sanitary manner in order to prevent food contamination. This had the potential to affect 86 of 86 residents who received food from the dietary kitchen. Findings include: The initial tour of the dietary kitchen was conducted on 3/31/14, at 9:30 a.m. with the certified dietary manager (CDM). During the tour it was noted the commercial grade meat slicer located on the kitchen food preparation counter had meat shavings evident under the blade sharpener at the top of the slicing blade. The blade sharpener and the surrounding slicer frame had evidence of food debris. The CDM verified the findings and stated the slicer was last used on 3/26/14 (5 days earlier) to cut meat for resident	F 371	St. John Lutheran Home will continue to store, prepare, distribute, and serve food under sanitary conditions. REGARDING CITED FINDINGS: The meat slicer and commercial grade can openers have been properly cleaned. IDENTIFYING OTHER RESIDENTS: All residents in the facality are at risk. CORRECTIVE MEASURES: Dietary staff will be retrained on the proper cleaning methods for kitchen equipment. The cleaning lists will be updated and reviewed with dietary staff to ensure they are aware of all items listed. MONITORING: Ongoing compliance will be maintained by routine checks of the kitchen equipment to ensure they are	5/12/14

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F 371	Continued From page 5 meals and should have been cleaned after use. It was observed that two commercial grade, manual, can openers were used in the kitchen. Both can opener cutting blades and assembly behind the cutting blades were noted to have a build up of a black sticky substance. The CDM verified the findings. During a subsequent visit to the dietary kitchen on 4/2/14, at 5:00 p.m. the meat slicer again was observed and continued to have food debris around the housing and frame of the blade sharpener. The findings were again verified by the CDM. The CDM stated staff had cleaned the unit but verified it needed further cleaning. During review of the kitchen cleaning schedule, it was noted the can opener and meat slicer were listed on the weekly cleaning schedule. The CDM stated staff do not routinely disassemble the can openers to clean behind the cutting blades. The CDM further stated staff should thoroughly clean the meat slicer after each use and also clean it weekly whether or not the equipment had been used. The manufacturer's instructions for cleaning the meat slicer include: the machine should be thoroughly cleaned and sanitized after each days' operation or after being idle for extended periods of time.	F 371	cleaned properly. The Dietary Manager and Assistant Dietary Manager will be responsible for compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		5/12/14

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F 441	Continued From page 6 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement proper infection control techniques when handling soiled linens and providing personal cares for 2 of 7	F 441	St. John Lutheran Home will continue to ensure that proper infection control techniques are used when handling soiled linen and providing personal cares for all	

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F 441	Continued From page 7 residents (R36 and R18) observed during personal cares. Findings include: During observation of evening cares on 4/2/14 at 7:12 p.m. nursing assistant (NA)-A and student NA were observed to provide bedtime cares for R36. R36 was observed seated in her wheelchair in her room. NA-A was observed to set up supplies for the bedtime cares: a basin of warm water, wash cloths and an incontinent brief. NA-A donned gloves and began washing R36's upper torso and face after removal of her shirt. Upon completion, NA-A and the student NA transferred R36 into the bed with the use of a mechanical lift. After positioning R36 in bed, NA-A and the student NA removed R36's pants by rolling her side to side. NA-B was observed to remove R36's incontinent brief with gloved hands. The brief was visibly soiled with fecal matter and urine. NA-A placed the soiled incontinent brief on the floor next to R36's night stand. Without changing contaminated gloves, NA-A then provided perineal care using a washcloth and towel. After completion of bedtime cares, NA-A placed the soiled washcloths and towels on the floor next to the soiled brief. NA-A was then noted to remove the soiled gloves and pour the water from the wash basin into the bathroom sink. NA-A returned to the bedside table and placed the wash basin into the nightstand. With bare hands, NA-A picked up the soiled brief, placed it in a plastic bag and transported it to the soiled utility room. NA-A touched R36's nightstand, her hair, the door handle, and the utility room door handle without proper handwashing.	F 441	residents including resident #36 and #18 IDENTIFYING OTHER RESIDENTS: All residents have been identified as being at risk for infections if improper handwashing and linen handling occurs. CORRECTIVE MEASURES: All direct care staff will be re-inserviced on the proper procedures for handwashing and the handling of soiled linens. MONITORING: The charge nurses will monitor handwashing and linen handling techniques on their shift by observing at least two different staff performing cares utilizing a rounds checklist form. The charge nurse will use the observation-rounds checklist as a teachable moment if problems are identified. The infection control nurse or designee will monitor general infection control practices on rounds 4 times a week and document and address issues identified as well as those identified by the charge nurse rounds checklists. Results of the monitoring will be reported to the QA&A committee on a quarterly basis and correlated with the facility infection control report. Compliance will be monitored by the Director of Nursing, Infection Control Nurse, RN Supervisors, and unit charge nurses.	

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F 441	Continued From page 8	F 441		

With bare hands, the student NA picked up the soiled washcloths and towels, placed them into a plastic bag, and carried the bag to the soiled utility room. The student NA also made contact with multiple surfaces with unwashed hands. Upon return to R36's room at 7:25 p.m. NA-A exited the room while pushing the mechanical lift into the hallway. No handwashing had yet occurred.

At 7:30 p.m. NA-A and the student NA were observed to enter R18's room to assist with bedtime cares. Neither NA-A or the student NA were observed to wash hands between cares for R36 and R18. NA-A and the student NA questioned whether R18 had completed her oral cares. R18 indicated it was completed. NA-A took the gait belt she was carrying and placed it around R18's waist and assisted R18 to the bathroom. Both NA's were observed to provide bedtime cares without proper handwashing.

On 4/3/14, at 7:35 a.m. the director of nursing (DON) was interviewed and made aware of the observations. The DON verified that staff were not to place soiled supplies/items on the floor and the residents all have extra plastic bags located in the garbage cans in their rooms for staff to use if needed to transport soiled clothing and incontinent products. The DON further stated the NA's were expected to wash their hands after handling soiled clothing or incontinent products.

The "Employee Handwashing Procedure" dated 6/2004, identified it was the policy of the facility that handwashing was the single most important means of preventing both residents and employees from the spread of infection.

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F 441	Continued From page 9 Under the procedure section of the policy, it was identified that staff should wash hands before and after delivery of care to residents, after removing gloves, and after potential contact with resident blood or body secretions.	F 441		

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. John Lutheran Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2014

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

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K 000	Continued From page 1 By e-mail 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. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: The original building was built in 1961 and was determined to be of Type II(000) construction; The 1st Addition was built in 1972 and was determined to be of Type II(000) construction; The 2nd Addition was built in 1987 and was determined to be of Type II(222) construction; The 3rd Addition was built in 1991 and was determined to be of Type II(222) construction, with a portion of the Addition being of Type V(111) construction; The 4th Addition was built in 2000 and was determined to be of Type III(211) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detectors in all Resident Rooms. The facility has a capacity of 95 beds and had a census of 87 at time of the survey.	K 000		

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K 000	Continued From page 2 Because all of the construction types & heights for an existing health care occupancy met the minimum requirements at NFPA 101 (2000) Table 19.1.6.2, the facility's construction type was downgraded to Type V(111) construction, and surveyed as one building. One Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect 35 out of 87 residents. Findings include: On facility tour between 11:00 AM and 3:30 PM on 04/02/2014, observation revealed, that the 2nd floor - 2 hour fire separation wall from Nursing Home to Vista Ridge has open penetrations around the duct work above the drop in ceiling.	K 011	The open penetration between the nursing home and Vista Ridge will be properly fire stopped. The plant operations director and/or designee will continue to monitor by conducting visual inspections to identify other potential penetrations.	5/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	**201 SOUTH COUNTY ROAD 5** **SPRINGFIELD, MN 56087**

(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 011	Continued From page 3 This deficient practice was confirmed by the facility Maintenance Director (JH) at the time of discovery.	K 011		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 25 out of 87 residents. Findings include: On facility tour between 11:00 AM and 3:30 PM on 04/02/2014, observation revealed that the following was found: 1. Basement - boiler room (west wall), open penetrations around several conduits	K 029	The penetrations in the basement boiler room will be properly fire stopped. The fire doors will be put back into place in the soiled linen chute room, and penetrations to the smoke barriers will be properly fire stopped. The Plant Operations Director and/or designee will assure ongoing compliance by performing visual inspections to identify and other potential penetrations.	5/12/14

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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K 029	Continued From page 4 2. Basement - soiled linen chute room (entrance wall). the drop in ceiling is resting on top of the corridor wall These deficient practices were confirmed by the facility Maintenance Director (JH) at the time of discovery.	K 029		
K 038 SS=F	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 provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect 50 out of 87 residents. Findings include: On facility tour between 11:00 AM and 3:30 PM on 04/02/2014, observation revealed that the 1st floor memory care unit and 2nd floor has magnetic locks on all exit doors. The following was found: 1. facility does not provide a manual unlocking and re-locking device at a central location	K 038	A manual unlock/re-lock switch for the magnetic locks in the facility will be installed at a central location. Key pads and switches in the facility that are more than 48 inches off the floor will be lowered to 48 inches or less. The Plant Operations Director will be responsible for maintaining compliance.	6/2/14

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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K 038	Continued From page 5 2. key pads or switches by the exit doors are not mounted between 34 to 48 inches off the floor These deficient practices were confirmed by the facility Maintenance Director (JH) at the time of discovery.	K 038		
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. The deficient practice could affect all 87 residents. Findings include: On facility tour between 11:00 AM and 3:30 PM on 04/02/2014, documentation review of the monthly emergency generator testing log (March 2013 to February 2014), indicated that the facility did not log the kilowatts or amperes. So it could not be determined if the diesel emergency generator was run under load at 30% of	K 144	Plant Operations staff will begin logging amperes when testing the emergency generator. The Plant Operations Director will be responsible for maintaining compliance.	5/12/14

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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K 144	Continued From page 6 nameplate rating or by one of the following means: 1. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or 2. under load of 30 percent or more of the nameplate rating of generator or 3. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) This deficient practice was confirmed by the facility Maintenance Director (JH) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		