DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5AKR

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID:			
1. MEDICARE/MEDICAID PROVID (L1) 245338 2.STATE VENDOR OR MEDICAID (L2) 079040100		3. NAME AND AI (L3) ST JOHNS I (L4) 901 LUTHE (L5) ALBERT LE	LUTHERAN I R PLACE		(L6)	56007	4. TYPE OF ACT. 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 12/1		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	JPPLIER CATEO 05 HHA 06 PRTF	GORY 09 ESRD 10 NF	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
8. ACCREDITATION STATUS: 0 Unaccredited	17/2015 (L34) (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENI 09/30	DING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	170 (L18) 170 (L17)	Compliance1. A B. Not in Con		gram	2. Tecl 3. 24 F 4. 7-D 5. Life	nnical Personnel	The Following Require _ 6. Scope of S _ 7. Medical E IF) _ 8. Patient Ro _ 9. Beds/Roo (L12)	Services Limit Director DOM Size	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY N	MEETS			
18 SNF 18/19 SNF 170	19 SNF	ICF	IID		1861 (e) (1) or	r 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC C	ANCELLATION	N DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUI	RVEY AGENCY	APPROVAL	Date:	
Kathryn Serie, Unit Supe	ervisor	1	2/29/2015	(L19)	Kamala Fiske	e-Downing, l	Enforcement Spe	ecialist 12/29/2015 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	C OFFICE O	R SINGLE S	TATE AGENCY		
DETERMINATION OF ELIGIBI	Participate		IPLIANCE WIT HTS ACT:	H CIVIL	2. (ncial Solvency (HCFA-2 ol Interest Disclosure St ::		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	ATION ACTION:	:	(L30)	
OF PARTICIPATION 08/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05-Fail t	UNTARY to Meet Health/Safety	
(L24)	(L41)		(L25)			on W/ Reimburse luntary Termination	on	to Meet Agreement	
25. LTC EXTENSION DATE:		IVE SANCTIONS n of Admissions:	(L44)		04-Other Reason	=	OTHER	ider Status Change	
(L27)	B. Rescind St	uspension Date:	(L45)						
28. TERMINATION DATE:	29). INTERMEDIARY			30. REMARKS	<u> </u>			
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVA	L DATE					
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL		



CMS Certification Number (CCN): 245338

December 29, 2015

Mr. Scot Spates, Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

Dear Mr. Spates:

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 December 13, 2015 the above facility is certified for:

170 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 170 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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 29, 2015

Mr. Scot Spates, Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

RE: Project Number \$5338026

Dear Mr. Spates:

On November 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 5, 2015. 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 December 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 17, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 5, 2015, effective December 13, 2015 and therefore remedies outlined in our letter to you dated November 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245338	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/17/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
ST	JOHNS LUTHERAN HOME		901 LUTHER PLACE ALBERT LEA, MN 56007	

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 Reg. # LSC	F0279 483.20(d), 483.20(k)(Correction Completed 12/13/2015	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 12/13/2015		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 12/13/2015
ID Prefix Reg. # LSC	483.35(i)	Correction Completed 12/11/2015	ID Prefix Reg. # LSC			Correction Completed 12/08/2015		ID Prefix Reg. #			Correction Completed 12/03/2015
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 12/11/2015	Reg. #			Correction Completed		ID Prefix Reg. #			Correction Completed
ID Prefix Reg. # LSC			Reg. #					ъ "			Correction Completed
ID Prefix Reg. # LSC			Reg. #					D "			
Reviewed E	By Review	ved Bv	Date:	Signature	of Sur	vevor:				Date:	
State Agen		-	12/29/20		0304	•					7/2015
	By Review		Date:	Signature						Date:	/2013
Followup t	o Survey Completed	on:		Check for any Uncorrected					Summary of the Facility?		NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245338	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 12/17/2015
Name of Facility		Street Address, City, State, Zip Code	
ST JOHNS LUTHERAN HOME		901 LUTHER PLACE	
		ALBERTLEA MN 56007	

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
		Coi	rrection				Correction					Correction
ID Prefix			mpleted 07/2015	ID Prefix			Completed 11/30/2015		ID Prefix			Completed 11/30/2015
Reg. #	NFPA 101			Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0062			LSC	K0154				LSC	K0155		
		0					0					0
			rrection mpleted				Correction Completed					Correction Completed
ID Prefix			inpleted	ID Prefix			Completed		ID Prefix			
Reg. #				Reg. #								
LSC				LSC					LSC			_
		Cou	rrection				Correction					Correction
			mpleted				Completed					Completed
ID Prefix				ID Prefix	-				ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			_
		Co	rrection				Correction					Correction
			mpleted				Completed					Completed
ID Prefix			•	ID Prefix			•		ID Prefix			_ `
Reg. #				Reg. #					Reg. #	-		
LSC				LSC					LSC			_
		Coi	rrection				Correction					Correction
			mpleted				Completed					Completed
Reg. #				Reg. #					Reg. #			_
				LSC					LSC			<u> </u>
Reviewed I		iewed By		Date:	Signature		-				Date:	
State Agen		/kfd		12/29/2		2582						7/2015
Reviewed I	Sy Rev	iewed By		Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comple				Check for any	y Uncor	rected Defic	cienci	es. Was a	Summary o	n	
	11/3/201	5			Shoomede	.a 50110	.5.15.53 (514)	200	, 55111 10	c i domity	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5AKR

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TATE SURVEY AGENCY Facility ID: 00138			
1. MEDICARE/MEDICAID PROVIDER N (L1) 245338 2.STATE VENDOR OR MEDICAID NO. (L2) 079040100	NO.	3. NAME AND AI (L3) ST JOHNS I (L4) 901 LUTHE (L5) ALBERT LE	LUTHERAN F R PLACE		(L6) :	56007	4. TYPE OF ACT	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)		7. PROVIDER/SU	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
6. DATE OF SURVEY 11/05/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR EN	IDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	170 (L18) 170 (L17)	Complianc1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	7. Medical	Services Limit Director toom Size
14. LTC CERTIFIED BED BREAKDOWN	I				15. FACILITY M	IEETS		
18 SNF 18/19 SNF 170	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMAR.	(L39)	(L42)	(L43)	I DATE).				
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17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL	Date:
Wendy Buckholz, HFE NE	II	1	2/07/2015	(L19)	Kamala Fiske	-Downing, l	Enforcement Sp	ecialist 12/11/2015 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR	SINGLE S	TATE AGENCY	
DETERMINATION OF ELIGIBILITY			IPLIANCE WITI HTS ACT:	H CIVIL	2. O		ncial Solvency (HCFA ol Interest Disclosure S ::	
22. ORIGINAL DATE 2	3. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	ΓΙΟΝ ACTION:		(L30)
OF PARTICIPATION 08/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Close		05-Fail	LUNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfactio 03-Risk of Involu		on	to Meet Agreement
		VE SANCTIONS n of Admissions:	(L44)		04-Other Reason	-	OTHE	vider Status Change
(L27)	B. Rescind St	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINA	ATION APPI	ROVAL	_



Protecting, Maintaining and Improving the Health of Minnesotans

7013 3020 0001 8869 0404 Electronically delivered November 20, 2015

Mr. Scot Spates, Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

RE: Project Number S5338026

Dear Mr. Spates:

On November 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

St Johns Lutheran Home November 20, 2015 Page 2

attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 13, 2015, 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 December 13, 2015 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

St Johns Lutheran Home November 20, 2015 Page 4

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 February 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

St Johns Lutheran Home November 20, 2015 Page 5

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:

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

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 12/07/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT			E SURVEY MPLETED
		245338	B. WING			11/	05/2015
	PROVIDER OR SUPPLIER IS LUTHERAN HOME			STREET ADDRE 901 LUTHER P ALBERT LEA		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTI H CORRECTIVE ACTION SHOUI -REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	The facility's plan of as your allegation of Department's acceptore enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated upon receipt of an on-site revisit of you validate that substates	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will	FO		DEFICIENCY)		
LADODATON	A DIDECTORIS OF PROVIDE	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

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

TITLE

(X6) DATE

12/04/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245338	B. WING	i		11/0	05/2015
	PROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	Continued From pa	ge 1	F(000			
F.070	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with		0.70			10/10/15
F 279 SS=D			F 2	279			12/13/15

-	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245338	B. WING _		11/05/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007			
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F 279	to develop, review a comprehensive pla. The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable	the results of the assessment and revise the resident's	F 27	,			
	be required under § due to the resident' § 483.10, including under § 483.10(b) (4) This REQUIREMENT by: Based on document facility failed to ensideveloped for use of for 1 of 5 (R171) reunnecessary medicine identified R171's actincluded a history of stage 3 and vitaminidentified was a dia	NT is not met as evidenced nt review and interview the ure a plan of care was of blood thinning medication sidents reviewed for		F279 R171 Comprehensive Care Plan versised on 11/04/15 to include blothinning medications. All comprehensive care plans for residents receiving blood thinning medications have been reviewed revised if needed. Nurse Managers were educated of including blood thinning medication the Comprehensive Care Plans. Thursing Newsletter date 11/20/15 included education on including blothinning medications on the Care	and on on ons on The also lood		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER IS LUTHERAN HOME	:		9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 LUTHER PLACE ALBERT LEA, MN 56007	•	
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F 279	10/7/15 indicated a Status score of 4 in impairment. The M required extensive perform activities of falls since prior ass R171's physician of 10/31/15 included (milligrams (mg) dainot eating 2 meals/note dated 8/14/15 of unprovoked DVT Coumadin. The physician of this was unprovoked recommended for loutweigh the benef R171's care pland for falls with major in skin integrity (brupropels wheelchair bars/railings, may be bars/railings, may	mum Data Set (MDS) dated Brief Interview for Mental idicative of severe cognitive DS further identified R171 assist of one person to f daily living and had 2 or more ressment. Inders for 10/7/15 through Coumadin (anticoagulant) 4.5 rily at bedtime for DVT. Hold if day. A physician progress identified R171 had a history for which she receives rysician stated, "Given the fact red, Coumadin was ife unless the risks of bleeding its." ated 10/20/15, included at risk injury and at risk for alteration uising/skin tears) related to	F 2	279	The Director of Nursing will audit Comprehensive Care Plans to ensiblood thinning medications are being planned appropriately. Audits will the weekly and reviewed at the next quexical QA/QI meeting for further recommendations.	ng care be done	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007	
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F 279	plans of care. The Coumadin pacrisk and can cause hemorrhage. Inser "instruct patient abominimize risk of ble symptoms of bleed other drugs, diets a increase the internatest that measures measure Coumadir "observe caution was to elderly patients in physical condition whemorrhage is presented." The facility policy A reviewed 8/2014, ice	kage insert warns of bleeding major bleeding or t included directions to but prevention measures to reding and report signs and ing." Package insert indicated ational normalized ratio (lab clotting time of blood used to a doses). The insert included, ith administration of Coumading any situation or with any where added risk of	F 279		
F 282 SS=D	bruising and MD/NI practitioner) to be ri 483.20(k)(3)(ii) SEP PERSONS/PER CATTHE SERVICES provided by accordance with eacare. This REQUIREMENT by: Based on interview facility failed to follow reporting bruising for the services provided by accordance with eacare.	P (medical doctor/nurse notified." RVICES BY QUALIFIED	F 282	F282 R148 bruising was assessed and documented on 11/04/15. Bruising will monitored until resolved.	12/13/15 be

CLIVILI	10 I OIT WILDIOATTL	& WILDIGAID SLITVICES			U	IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
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F 282	for 2 of 2 residents positioning needs. Findings include: On 11/3/15, at 4:18 her room sitting upr was noted to have a located on her right circular bruise was yellow/purple bruise arm biceps area a copurple/yellow bruise circular shape. The as if they could be fiddn't know how shino one hurt her. Brams. The care plan dated an alteration in bath interventions included problems and declinal tered skin integrity. Monitor for breakdod. The progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress note of nurse (RN) on the path of the progress nurse (RN). The identified bruise the path of the progress nurse (RN) on the path of the progress nurse (RN) on the path of the progress nurse (RN).	p.m. R148 was observed in right in the wheelchair. R148 a large circular purple bruise mid forearm. Above the noted a V shaped lighter a. Also noted on R148's left cluster of 4 smaller circular as which were in a semi as 4 smaller bruises appeared inger marks. R148 stated she agot the bruises but indicated 148 had geri sleeves on both and October 2015, identified: (1) hing/grooming/dressing with ing: Observe and report skin he to nurse and (2) at risk for y with interventions including: own with cares/bath. The entered by the registered obysician orders dated 9/1/15 and the record dated 11/1/5 to skin was to be checked on a skin was to b	Fí	2282	R139 bruising was assessed and documented on 11/17/15. Bruising monitored until resolved. Nursing staff were educated on 12 to report skin concerns to Licensed Nurses and Licensed Nurses were educated to complete documentation and the proper monitoring of skin concerns and proper documentation occurred, and will forward any content DON. Results of audits will be reviewed at the next Quarterly QA/meeting for further recommendation R153 O.T. was ordered for resider 11/06/15 for chair positioning. R136 was assessed and treated for proper positioning while in chair on 11/06/15. Nursing staff were educated on 12 for proper chair positioning. Nurse Managers and Licensed Nurses we educated on proper chair positioning. Concern for proper chair positioning. Concern for proper chair positioning. Concern for proper chair positioning. Results audits will be reviewed at the next Quarterly QA/QI meeting for further recommendations.	on. udits to kin has cerns to QI has. It on has reference to the control of the c	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER IS LUTHERAN HOME			901	REET ADDRESS, CITY, STATE, ZIP CODE LUTHER PLACE BERT LEA, MN 56007		
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F 282	(CM)-B. CM-B state located on the top of finger marks. Whe treatment, R148 stabruises had not been the care plan had not be the care plan had not he bruising should cares and reported. On 11/5/15, at 3:21 documented in the the right forearm at x 1.4 cm. Bruises to measured 1.7 cm x and 1.2 cm x 0.5 cm. On 11/3/2015, at 12 sitting in the dayroom noted dark purple, or right forearm aboved dime size purple/yer forearm below the aunable to verbalize occurred. When as he replied, "well I have replied, "well I have replied, "well I have replied, "well I have replied, interventions breakdown with care (2) alteration in bath with interventions in skin problems. When interviewed on ursing assistant (N	ed at this time the bruises of R148 left arm appeared like in questioned about rough ated, "no". CM-B verified the en reported and subsequently ot been followed. She stated have been identified with to the nurse. p.m. the bruises were chart with measurements of s 2.1 cm x 1.4 cm and 4.2 cm of the left upper extremity 1.3 cm, 0.3 cm in diameter	F 2	82			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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	PROVIDER OR SUPPLIER IS LUTHERAN HOME			STREET ADDRESS, CITY, STATE 901 LUTHER PLACE ALBERT LEA, MN 56007	E, ZIP CODE		
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F 282	noticed the bruises expected to report to conditions/bruising. Interview with CM-Everified R139's bruidentified, reported CM-B verified the cimplemented as writed the cimplemented as writed to complemented to complement	NA-D stated staff were o the nurse when skin were discovered. Son 11/4/15, at 1:49 p.m. ising should have been to the nurse and monitored. are plan had not been	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY MPLETED
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F 282	recall ever having a R153 always tende fashion, or crossed upward by the when his legs. NA-B furt longer propel his withe ability in the past R153's care pland a problem of impaired and physical impaired to/from destination 1; Encourage to procues; Monitor posi Monitor for change When interviewed 62:05 p.m. CM-B and seated in his w/c in R153 was finishing NA-B. R153's w/c balls of R153's feet NA-B confirmed that intermittently while times, his feet do not werified R153's chafor support/proper pareclined position. R136's care pland deproblem of impaired and cognitive impaire	st for his w/c, NA-B could not a footrest. NA-B indicated d to hold his legs out in this his legs, or pulled them el of the chair but didn't dangle her verified R153 could not /c independently though had st. ated 9/22/15 included a d physical mobility r/t cognitive ment. Intervention dated Jses w/c/Rock-n-Go to move on/off unit with asst (assist) of topel self short distances with tioning prn (as needed); and in abilities." on 11/5/15, at approximately d surveyor observed R153 the 1st floor NE solarium. his lunch with assistance from was in the upright position, the conly were touching the floor.	F 282			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
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her room seated in was locked in a ser residents legs and approximately 10-1 footrests attached tupward. On 11/05/15, at 4:5 observed R136 in h dangling. CM-B co locked semi-recline resident's feet could put the footrest on I position and confirm a down position R1 the footrests when positioned correctly improper positioning. On 11/05/15, at 5:0 observed R136 seafeet dangling. DON dangling and that it 483.25 PROVIDE CHIGHEST WELL BIE Each resident must provide the necessior maintain the high mental, and psychological plan of care.	her Rock-n-go w/c. The w/c mi-reclined position; the feet were observed dangling 2 inches from the floor. The o the chair were raised 5 p.m. CM-B and surveyor fer w/c in room with feet infirmed R136's chair was in a individual distribution and that the dinot touch the floor. CM-B R136's chair in the downward fined that even when placed in 36's feet could still not touch reclined and was not in c. CM-B confirmed the information of the confirmed R136. 30 p.m. the DON and surveyor sted in her room in w/c with all confirmed R136's feet were was an issue. 30 c. CARE/SERVICES FOR EING 31 receive and the facility must fary care and services to attain finest practicable physical, is social well-being, in a comprehensive assessment				12/13/15
	ion, interview, and document		F309		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PARTICIPATION OR LETTER CONTINUED CONTINU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 her room seated in her Rock-n-go w/c. The w/c was locked in a semi-reclined position; the residents legs and feet were observed dangling approximately 10-12 inches from the floor. The footrests attached to the chair were raised upward. On 11/05/15, at 4:55 p.m. CM-B and surveyor observed R136 in her w/c in room with feet dangling. CM-B confirmed R136's chair was in a locked semi-reclined position and that the resident's feet could not touch the floor. CM-B put the footrest on R136's chair in the downward position and confirmed that even when placed in a down position R136's feet could still not touch the footrests when reclined and was not positioned correctly. CM-B confirmed the improper positioning for R136. On 11/05/15, at 5:00 p.m. the DON and surveyor observed R136 seated in her room in w/c with feet dangling. DON confirmed R136's feet were dangling and that it was an issue. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER S LUTHERAN HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 her room seated in her Rock-n-go w/c. The w/c was locked in a semi-reclined position; the residents legs and feet were observed dangling approximately 10-12 inches from the floor. The footrests attached to the chair were raised upward. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
	245338	B. WING		11/0	05/2015
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bruising for 2 of 3 reviewed for non and failed to prov support positionin R136) reviewed w Findings include: On 11/3/15, at 4:1 her room sitting u was noted to have located on her rig circular bruise way yellow/purple brui arm biceps area a purple/yellow brui circular shape. Tas if they could be didn't know how so no one hurt her. arms. Review of the 9/2 (MDS) indicated a Status score of 5 cognitive impairm needed with activ The progress not nurse (RN) on the through 9/30/15, i intact. The treatn 11/30/15 indicated bath day and brui	failed to identify and monitor (R148, R139) residents pressure related skin conditions, ide proper wheelchair and foot g for 2 of 2 residents (R153, with positioning needs. 8 p.m. R148 was observed in pright in the wheelchair. R148 e a large circular purple bruise ht mid forearm. Above the s noted a V shaped lighter se. Also noted on R148's left a cluster of 4 smaller circular ses which were in a semi he 4 smaller bruises appeared e finger marks. R148 stated she she got the bruises but indicated R148 had geri sleeves on both 9/15, annual Minimum Data Set a Brief Interview for Mental which is indicative of severe ent and extensive assistance ities of daily living (ADL's). The entered by the registered e physician orders dated 9/1/15 dentified bruises easily but skin ment record for 11/1/5 to d., Skin was to be checked on se, rash, open area etc. was to The treatment record also	F 309	R148 bruising was assessed ar documented on 11/04/15. Bruis monitored until resolved. R139 bruising was assessed ar documented on 11/17/15. Bruis monitored until resolved. Nursing staff were educated on to report skin concerns to Licen Nurses and Licensed Nurses we educated to complete document Nurse Managers will do on-goin ensure that proper monitoring of concerns and proper document occurred, and will forward any of the DON. Results of audits will reviewed at the next Quarterly Comeeting for further recommends R153 O.T. was ordered for residual 11/06/15 for chair positioning. R136 was assessed and treated proper positioning while in chair 11/06/15. Nursing staff were educated on for proper chair positioning. Nu Managers and Licensed Nurses educated on proper chair positioning. Cobe forwarded to the DON. Results will be reviewed at the net Quarterly QA/QI meeting for fur recommendations.	sing will be ad ad adding will be adding will be all 2/04/15 sed ere atation. g audits to f skin ation has oncerns to be QA/QI ations. dent on all for an adding sere adding. g audits adding.	

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F 309	interventions included problems and declar altered skin integrit Monitor for breakd. The identified bruis interview on 11/4/1 manager (CM)-B. Stop of R148 left are She asked R148 w R148 stated "no". not been reported identified, reported in the right forearm at 1.4 cm. Bruises measured 1.7 cm; and 1.2 cm x 0.5 cm. On 11/03/2015, at sitting in the dayrounded dark purple, right forearm above dime size purple/yeforearm below the unable to verbalize occurred. When as he replied, "well I have been also in the reported identified in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked on bath displays and declar in the complete needed with ADL's record for 11/1/15 checked	hing/grooming/dressing with ding: Observe and report skin ine to nurse and (2) at risk for ty with interventions including: own with cares/bath. sed areas were noted during 5, at 1:49 p.m. with clinical She stated the bruises to the m looked like finger marks. Whether anyone was rough and CM-B verified the bruises had and should have been to the nurse and monitored. I p.m. the bruises were chart with measurements of as 2.1 cm x 1.4 cm and 4.2 cm to the left upper extremity x 1.3 cm, 0.3 cm in diameter	F 3	09		

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_	PROVIDER OR SUPPLIER NS LUTHERAN HOME			90	REET ADDRESS, CITY, STATE, ZIP CODE 1 LUTHER PLACE BERT LEA, MN 56007		
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F 309	Review of the care identified: (1) at ris bruising, skin tears aggressiveness, an object; interventions breakdown with car (2) alteration in bath with interventions in skin problems. When interviewed on ursing assistant (Nassisted R139 with noticed the bruises expected to report to conditions/bruising. Interview with CM-Everified the bruising reported to the nursing assistant (NE) the room. R153's viseated in a Rock-nfloor northeast (NE) the room. R153's visemi-reclined positional hold his legs/feet upwere no leg/foot support of the widen support	plan dated September 2015, k for alteration in skin integrity, related to a history of physical d bumps into doors and sincluded: Monitor for es/bath. Also identified was: ning, grooming and dressing acluding: Observe and report on 11/4/15, at 12:30 p.m. JA)-D confirmed she had morning cares and had not NA-D stated staff were to the nurse when skin were discovered.	F3	09			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245338	B. WING			11/(05/2015
	PROVIDER OR SUPPLIER			901	REET ADDRESS, CITY, STATE, ZIP CODE I LUTHER PLACE BERT LEA, MN 56007		, = 0 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	(NA)-B for the brea in his Rock-n-go w/balls of his feet wer There were no foot w/c. NA-B assisted w/c remained in the a.m., NA-B was obs w/c closer to the wi locked R153's w/c loser to the wi locked R153's w/c loser to the wi locked R153's w/c loser to the wi locked R153's legheld upward stretch NA-B was question utilized a leg/footrer recall ever having a R153 always tende fashion, or crossed upward by the wheeh lis legs. NA-B furtl longer propel his with eability in the passible of the with bed mobility, trhygiene, locomotion dressing. The MDS long term memory impairment related R153's care plan daproblem of impaired and physical impair 2/25/15 included: "It to/from destination 1; Encourage to procues; Monitor position of the problem of the problem of impaired and physical impair 2/25/15 included: "It to/from destination 1; Encourage to procues; Monitor for changes."	kfast meal. R153 was seated c in an upright position, the e observed to touch the floor. nor leg rests observed on the R153 with eating while his e upright position. At 9:56 served to move R153 in his ndow. NA-B adjusted and pack to a semi-reclined ps/feet were observed to be ned out in front of him. When ed whether R153 had ever st for his w/c, NA-B could not a footrest. NA-B indicated d to hold his legs out in this his legs, or pulled them el of the chair but didn't dangle her verified R153 could not for independently though had st. mum Data Set (MDS) dated stensive assistance from staff ansfer, eating, personal n on unit, toilet use, and a further indicated short and problems and severe to (r/t) daily decision making. ated 9/22/15 included a d physical mobility r/t cognitive ment. Intervention dated Uses w/c/Rock-n-Go to move on/off unit with asst (assist) of opel self short distances with tioning prn (as needed); and	F3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245338	B. WING _		11	/05/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	an assessment by w/c positioning. When interviewed manager (CM)-B cd did not evaluate R1 stated the facility re Rock-n-go w/c as it and would decreas approximately 2:05 observed R153 sea NE solarium. R153 assistance from Naupright position, on touching the floor. recline the resident confirmed that whe touch the floor. CN in need of a leg/foo would not be good positioned in a recl When interviewed director of nursing OT had evaluated I and further stated i they would request confirm or deny wh positioning when releg/footrests as this resident. R136's quarterly M total dependence won unit, and extens mobility, dressing, hygiene. The MDS long term memory	occupational therapy (OT) for on 11/5/15, at 1:59 p.m. clinical onfirmed the OT department 53 for w/c positioning. CM-B equested an order for the twould be more comfortable et the risk for falls. At p.m. CM-B and surveyor ated in his w/c in the 1st floor 3 was finishing his lunch with A-B. R153's w/c was in the ly the balls of R153's feet were NA-B confirmed she would at times in his w/c and further on she does this his feet cannot M-B verified R153's chair was strest and further confirmed it for the resident to be ined position without one. On 11/05/15, at 4:21 p.m. the (DON) stated being unaware if R153 r/t wheelchair positioning the was individualized as to when this. The DON could not be either the resident's w/c eclined was appropriate without its was individualized with each of DS dated 10/2/15 indicated with transfers and locomotion ive assistance with bed eating, toilet use, and personal 5 further indicated short and problems and severe to (r/t) daily decision making.	F 30	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 309	problem of impaired and cognitive impaired and confirm down the resident's footrests when reclimited and confirm down the resident's footrests when reclimited and cognitive impaired and confirm down the resident's footrests when reclimited and cognitive and confirm down the resident's footrests when reclimited and cognitive and confirm down the resident's footrests when reclimited and cognitive and cognitive and confirm down the resident's footrests when reclimited and cognitive and c	ated 10/16/15 included a d physical mobility r/t physical rment. Intervention dated Uses w/c or Rock N Go for off the unit with assist of 1. itioning. Report changes" 0 p.m. R136 was observed in her Rock N Go w/c. The w/c ni-reclined position; the feet were observed dangling 2 inches from the floor. The o the chair were raised up. 5 p.m. CM-B and surveyor per w/c in room with feet nfirmed R136's chair was in a d position and that the d not touch the floor. CM-B R136's chair in the downward feet could still not touch the ned. CM-B confirmed the g for R136 and stated she	F 3	09		
F 371 SS=F	On 11/05/15, at 5:0 observed R136 sea feet dangling. DON dangling and that it 483.35(i) FOOD PF STORE/PREPARE/ The facility must - (1) Procure food from	00 p.m. the DON and surveyor ted in her room in w/c with I confirmed R136's feet were was an issue.	F 3	71		12/11/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		SURVEY PLETED
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F 371	(2) Store, prepare, under sanitary cond	distribute and serve food	F 371			
	by: Based on observareview the facility for (can opener) utilized clean and sanitary potential to affect a facility who consum kitchen. Findings include: The initial kitchen the at 11:45 am. with the food service manage tour the following some The electric can oppreparation processervice counter. A substance was evicand on the back side thick, black oily subfront surface of the heavily soiled black and around the cut opener located on above findings were When the kitchen of the surface of the lateral around the cut opener located on above findings were When the kitchen of the lateral around the kitchen of the lateral around the cut opener located on a lateral around the cut opener located on the lateral around the kitchen of the lateral around the kitchen of the lateral around the kitchen of the lateral around the lateral around the kitchen of the lateral around the lateral	tion, interview, and document ailed to maintain equipment of in food preparation in a condition. This had the II 134 residents residing in the ned foods served from the our was conducted on 11/2/15, ne facility dietician (RD) and ger (DM). During the initial anitary concern was noted: where utilized in various food ses was located on the food thick buildup of a black oily dent in the area located under de of the cutting blade. This estance was dripping down the can opener. In addition, a a substance was evident on ting blade of the manual can		F371 All can openers were taken apart athoroughly cleaned on 11/2/2015 be Dietary Manager. The cleaning of copeners has been added to the diecleaning schedule. On 12/1/15 an in-service for the diestaff was held by the Registered Dietary Manager to address sanitation and the updated cleaning schedule. Weekly audits of the cleanliness of kitchen will be conducted by the Registered Dietician and/or Dietary Manager for two months to ensure compliance. After the two month permonthly audits will continue to occuping audits and cleaning schedules continue to be monitored by the Registered Dietician and discussed Quality Assurance meetings.	y the can etary etary ietician g f the car. The acted on a will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245338	B. WING		11/0	05/2015
	PROVIDER OR SUPPLIER IS LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007	,	
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F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spre (1) When the Infection determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each din hand washing is incorposessional practice (c) Linens Personnel must hand	of Program stablish an Infection Control ch it - Introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective offections. The add of Infection stand Control Program esident needs isolation to of infection, the facility must asset or infected skin lesions with residents or their food, if the ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44			12/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245338	B. WING _	 	11/0	05/2015
_	NAME OF PROVIDER OR SUPPLIER ST JOHNS LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP (901 LUTHER PLACE ALBERT LEA, MN 56007	· ·	
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F 441	by: Based on observareview the facility facontrol procedures resident (R92) who precautions. Findings include: It was was observed personal protective gloves and gowns Rubbermaid contains R92's room. Therefore the door of this rood precautions nor was located in the threeform any special contact. When interviewed nursing community week R92 was condidn't know with who gown was required bathroom. NCA-A PPE outside the docontagious. On 11/3/15, at 5:53 stated R92 had Clothey couldn't post sof the problem with this information to report. CM-A state to wear gloves, goinstruct R92 to was the room. CM-A als	NT is not met as evidenced ation, interview and document ailed to ensure proper infection were implemented for 1 of 1 or required special contact ed on 11/3/15, at 5:42 p.m. that e equipment (PPE) including was stored in a three drawer iner located outside the door of e was no magnet located on om to alert staff of special as there any information e drawer container related to	F 4	F-441 Resident 92 had sign place door indicating to check wit entering on 11/6/15. Re-education of R92's nurs was put in their communication to the isolation precautions R92. All nursing staff (licensed a are being re-educated and newly developed C. Diff. Prat all reports for all shifts for December 3 through Decer Staff are educated as to whom the compliance with infection conformation of practices, and St. John Control Policy. The kit has a the nurse" sign, and the communication book, an expending that needs to be implement the precautions, notification sheet to be placed communication book, an expending the precautions of the precautions for staff. The Resident compliance. This education will also be during orientation with newled licensed staff.	ch nurse before ses and CNA's ation book on on alerted staff needed for and certified) updated on the recautions Kit or 5 days dated onber 8, 2015. The Precaution stions to ensure control standard os Infection a" check with reet for done to a specific red in the ducational and offact in Infection contact reviewed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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F 441	nursing assistant (I of the special precishe hasn't worked doesn't work very of During an interview	on 11/4/15, at 10:07 a.m. NA)-A stated she was unaware autions required for R92 as since last weekend and	F 44	.1			
	resident requires s is alerted by placin door. RN-A stated information in the container which excontact precaution the NA's communidocumentation/not who require special explained that nurs	pecial contact precautions staff g a magnet on the resident's she also places printed drawer of the Rubbermaid plains to staff the type of s required. RN-A also stated cation book should include ification related to residents al contact precautions. RN-A sing staff should review the ok every time they work.					
	RN-A verified there identifying that spe required nor was the available in the Rulagreed that family to any special contexts system evident where identified in the reconstruction of the reconstructi	ewed on 11/5/15, at 12:04 p.m. e was no magnet on R92's door cial contact precautions were here printed information bbermaid container. RN-A also and/or visitors were not alerted act precautions nor was ich alerted them to check with o their visit and/or entering the					
	verified the Certifie hour care guide for assistant communi documentation ind	on 11/5/15, at 4:01 p.m. CM-A d Nursing Assistant initial 24 r R92 included in the nursing location book did not have licating R92 had C-diff nor did it sary infection control					

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F 441	when providing care reduce the risk of to	ge 20 precautions to implement es. The facility procedure to cansmission between el and visitors had not been	F 44	1	
F 463 SS=E	The policy Isolation Precautions, review purpose as: To red disease transmission protect personnel a recognized sources identified the follow Precautions will be Standard Precautions uspected to be informationally suspected to be informationally suspected to be informationally suspected in the specific microorgand droplet, or contact a Identified Resident be instructed in the Precautions. When place, visitors are entering and leaving 483.70(f) RESIDEN ROOMS/TOILET/B	IT CALL SYSTEM -	F 46	3	12/3/15
	by: Based on observative review the facility faresident (R33, R75)	NT is not met as evidenced tion, interview, and document alled to ensure that 5 of 40, R106, R139, R142) call lights tioning properly so that		F463 The call light in room 116 was repaired tested, and then returned to the room of 11/3/15 by maintenance staff. The	

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F 463	residents had a media Findings include: During an observat R139's bedroom (rwithout a call light; function. When int p.m. licensed pract R139's bathroom of LPN-B further states stopped functioning given to maintenant. During an observat R142's (room 172) activated. Upon puthe call light unit state call light did not regor the resident's root station, indicating the call light was not LPN-C further verifical light had been system routinely alterating the nursing call light had been system routinely alterating the nursing call light had been system routinely alterating the nursing call light had been system routinely alterating the nursing call light had been system routinely alterating the nursing as she bring it to main During an observat R106's (room 109) lights were tested/affunctional.	tion on 11/3/15, at 12:28 p.m. oom 116) was observed the bathroom call light did not erviewed on 11/3/15, at 12:29 ical nurse (LPN)-B confirmed all light was not functioning. The detail light was not functioning. The detail light was not functioning and had been ace for repair. Ition on 11/3/15, at 12:35 p.m. bathroom call light was allling the cord, the red light on arted to blink. However, the gister on the marquee outside om near the 1 South nurse's he call light had been or alerted LPN-C who verified of registering on the marquee. I ied the call light was not a staff on their radio's that the activated. The call light erts nursing staff on their not call lights are activated. I is bathroom call light to a sistant (NA) and asked that	F 463	bathroom call light battery in room was replaced, the call light was test assure that it was operating correct then returned to the room by maintestaff on 11/3/15. The call light battery in room 172 w replaced, tested by maintenance st assure that it was operating correct then returned to the room on 11/3/17. The call light batteries in the bedroe bathroom of room 109 were replaced tested to assure that it was operating correctly, and then returned to the roon 11/3/15. The call light cord in room 124 was replaced by a new pressure sensitively maintenance staff on 11/3/15. The call light cord in room 124 was replaced by a new pressure sensitively maintenance staff on 11/3/15. The tall light was operating properly. The battery was also tested to assure the call light transmitter was reprogrammed, the batteries were replaced, the transmitter was tested assure correct operation, and then returned to the room by maintenance 11/3/15. The call box jack in room 136 was replaced, tested to assure proper operation, and then returned to the 136 by maintenance on 11/3/15. Access to a daily maintenance reposition of the call light was established EVS Director on 11/4/15. This report of isolate maintenance issues and which call lights need attention. Advanced Wireless technicians we contacted on 11/4/15 and came to facility on 11/6/15 to assess and as	ted to cly, and cenance as aff to cly, and 5. com and ced, ng room we cord ne nat the ne d to ce on room ort that clems for the rt helps identify re che	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 463	Nursing assistant (I the call lights were continued to test the attempts both call light activated the call light activated the call light and did not function surveyor that some becomes loose and into the call light both the surveyor pushed the call light function. On 11/4/15, at 8:30 seated in recliner in When questioned both athroom call light don't know, I don't know, I don't know, I don't know and light began R142. When the more room was checked light had been active R142's call light was marquee nor was it radio's. LPN-C the and gave it to environ (ESS)-A to repair. When interviewed of stated the call light since it was installed maintenance was of stated the nursing as be checking to make	and neither functioned. NA)-C was alerted and verified not functioning. NA-C e call lights and after several ghts eventually functioned and ght system. ion on 11/3/15, at 1:51 p.m. edroom call light was tested n. R75 indicated to the times the call light cord if needs to be pushed back up x unit. Subsequently, when d the cord into the box unit,	F 4	163	system were operational. On 11/17/15 the EVS Director and Volunteer Coordinator developed a Call Light Repair Form for staff to use the event that they notice a call light malfunction. The form includes a troubleshooting checklist, and a cacopy of the form is created when the filled out. In addition to the Call L Repair Form a Repair Log was creatively and replacements. The Administrator, EVS Director, and Volunteer Coordinator held a confecall with the lead technician at Adva Wireless on 12/1/15 to discuss furt improvements to the system. Adva Wireless programing support staff valso on this conference call. The lead technician at Advanced Wis scheduled to come to the facility 12/3/15 to further refine the function the call light system. Audits of randomized call lights will conducted monthly and rotate througach wing of the building. The corrective action regarding F46 completed on 11/7/15. The EVS Director will continue to m (1) Daily Call Light Maintenance Resent by Advance Wireless, (2) the Call Light Repair Forms, and (3) the Real Log. This will be a daily and ongoin responsibility of the EVS Directors event that the EVS Director is out to building, the lead maintenance main be trained to check, monitor and rethe call light system.	rbon le form ight lated on lual call rence lanced her nce were Vireless on hality of be ligh 63 was honitor eports Call pair g In the of the n will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIEICATIONI NII IMPED: ` ´		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 463	ESS-A confirmed the perform routine auditated there had be implementing mont	to notify maintenance. nat maintenance staff did not dits on the call light system but en talk this week of	F 4	∙63				
	environmental servicularity volunteer coordinate not have a formal a lights were function when a call light was instructed to put it is maintenance staff to was their only proceed that on 11/3/15 after above call light is suidentified 4 other renon-functional. Esta Advanced Wireless that installed/service to the facility on 11/education related to ESD stated there we printed daily that we such as a low batter battery warning), alteregistering on the maior or vice/versa, pulled away from the check-in failure). Ereport existed and verport daily to ident VC verified that if a	ices director (ESD) and or (VC) verified the facility did uditing system to assure call ing properly. ESD stated ing properly. ESD stated in a designated box for the orepair. ESD confirmed this is ess. ESD further confirmed the is a maintenance staff sident call lights that were in a staff from a Communications (company is est the call light system) came is a report that could be included in the could identify call light issues in the a faulty cord or if the unit had in the wall (indicted on report as: SD stated being unaware this would now be reviewing the ify potential call light issues. call light was activated and unit was blinking but it did not						
	show up on the rep	quee or the radio it would not ort. VC stated they had plan into place to audit 1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
		245338	B. WING _		11	/05/2015		
	NAME OF PROVIDER OR SUPPLIER ST JOHNS LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP COE 901 LUTHER PLACE ALBERT LEA, MN 56007				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 463	neighborhood each call lights manually audits were not bei or nursing staff. When interviewed ESD stated the nur email from Advance r/t call light response ESD further stated report. ESD stated there would be a lot the nurse manager information to main stated being unsurpotential call light is when interviewed clinical manager (Cisn't functioning produplicate work order maintenance will pick. When interviewed clinical manager (Cisn't functioning produplicate work order maintenance will pick. CM-C further stated the old call light system affected resident as functional. CM-C communications eindicating call light previous day. CM-from the previous day. The report included times and the end maintenance issue not address the mass it was her under received the same	age 24 In week of the month to check I; ESD and VC verified call light Ing performed by maintenance on 11/05/15, at 12:35 p.m. the Ise managers received a daily Ited Wireless Communications Ited ise times for the previous day; Inot having access to this It this report also indicated if It we battery on a call light and Ited swould forward this Itenance to address. ESD Ite if the email indicated other Issues other than a low battery. In 11/05/15, at 1:26 p.m. In 11/05/15, at 1:26	F 46	3				

PRINTED: 12/07/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245338	B. WING			11/0	05/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 901 LUTHER PLACE ALBERT LEA, MN 56007	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 465 SS=E	CM-B verified she refrom Advanced Wir light response times CM-B displayed the for surveyor to reviet the maintenance see on CM-C 's activity light audits were not on a regular basis. When she worked uperiodically check the experienced a reside for help because he CM-B stated after the light checks but had practice since movifirst floor. CM-B stated after the building - if not and put in a box do broken call lights are being repaired the complemented for the When interviewed to 2:30 p.m. CM-A stated forwarding the Adva Communications discall light response to their email list. 483.70(h)	on 11/05/15, at 1:47 p.m. received a daily activity report reless Communications r/t call refers from the previous day. redaily report on her computer rew; the report did not include rection as previously visualized report. CM-B confirmed call reports to being performed by nursing reports call lights as a floor nurse would recall lights as had recall lights as had recall light battery was dead. The call light battery was dead recall light battery was dead recall light battery was dead recall light battery was dead. The call light battery was dead recall light battery was dead. The call light battery was dead recall light battery was dead. The call light battery was dead recall light battery was dead. The call light is on on the recall light is on on the placed. If a call light is recall light battery was dead. The call light is on on the placed. If a call light is recall light battery was dead. The call light is on the placed. If a call light is recall light battery was dead. The call light is on the placed of the call light is recall light battery was dead. The call light is on the placed of the call light is recall light battery was dead. The call light battery was de	F 4				12/11/15
	The facility must pro	ovide a safe, functional,					

PRINTED: 12/07/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245338	B. WING		11/0	5/2015	
	PROVIDER OR SUPPLIER IS LUTHERAN HOME	:	9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 LUTHER PLACE ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 465	sanitary, and comforesidents, staff and This REQUIREMED by:	ortable environment for	F 465	F465			
	review the facility fa equipment in a clea promote sanitation kitchen. This prace	ailed to maintain kitchen an and sanitary manner to and food safety in the dietary tice had the potential to affect ho received food from the		1. On 11/2/15 the upright storage was cleaned and excessive food was removed from the bottom of the free the Dietary Manager. Cleaning the storage freezer was added to the recleaning schedule. On 12/1/15 sani practices and the re-developed cleanschedule was reviewed with dietary	ezer by upright egular itary aning staff.		
	at 11:45 am. with the food service manage tour the following s 1. The upright storal identified to have equilibrium building (heavily soil)	our was conducted on 11/2/15, ne facility dietician (RD) and ger (DM). During the initial anitary concerns were noted: age freezer in the kitchen was excessive food and debris led) on the bottom of the		2. On 11/2/15 the fire suppression lines under the cook stove hood we cleaned by the dietary staff. Cleanir fire suppression feed lines under th stove hood has been added to the maintenance regular cleaning sche On 12/1/15 sanitary practices and t re-developed cleaning schedule wa reviewed with dietary staff.	ere ng the e cook dule. he		
	freezer were stored debris and particles 2. The fire suppres stove hood were no grease and dust. T dust which was har time of the observal large pots of Bratw heavily soiled feed			3. On 11/2/15 the wall on the left set the cook stove adjacent to the cook hood was cleaned by dietary staff. Cleaning the walls near the cook st hood has been added to the regula maintenance cleaning schedule. On 12/1/15 sanitary practices and the re-developed cleaning schedule was reviewed with dietary staff. 4. On 11/2/15 boxes were removed the floor of the large walk-in storage freezer in the basement by the dietary staff.	ove r n as ed from e ary		
	adjacent to the coo	eft side of the cook stove k stove hood was also noted ild up of dust and a coating of		manager. The floor is scheduled to cleaned by maintenance on 12/4/15 Cleaning the floor has been added	5.		

PRINTED: 12/07/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245338	B. WING			11/0	5/2015
_	PROVIDER OR SUPPLIER	•		9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	grease. The fire su on the wall running heavily soiled. 4. The large walk-in basement was noted didentified the boxes previous Friday and appearing floor sind available shelving i with supplies. The expectation/standa shelves and not on During the tour on above findings were The DM stated the routinely cleaned or to the fire suppress as part of routine cleaning list failed to the upright freezer. That the back wall as	ppression system feed lines vertical were also noted to be a storage freezer in the ed to have boxes of chicken irectly on the floor. The DM is had been delivered on the dinad been left on the dirty be delivery. It was noted the in the freezer was already filled DM verified the dietary rd was to store items on the floor in the walk-in freezer. 11/2/15, at 11:45 a.m. all of the e verified by the RD and DM. hood over the cook stove was in a schedule but the feed lines sion system were not identified leaning. Review of the kitchen in identify cleaning the inside of The cleaning list identified adjacent to the cook stove aned on a daily basis.	F 4	465	regular maintenance cleaning sche On 12/1/15 sanitary practices and tre-developed cleaning schedule wareviewed with dietary staff. Weekly audits of the cleanliness of kitchen will be conducted by the registered dietician and/or dietary manager for two months to ensure compliance. After the two month permonthly audits will continue to occur first audit is scheduled to be conducted to be conducted to be conducted to be monitored by the Registered Dietician and discussed Quality Assurance meetings.	the eriod, ur. The cted on will	

F5338024

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245338	B. WING			11/0	3/2015
	PROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 11 LUTHER PLACE LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS F COMPLIANCE.				0 40 E- Ĉ.S.	
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.					U=
	Minnesota Departr Fire Marshal Divisi St. Johns Lutherar substantial complia participation in Me Subpart 483.70(a) 2000 edition of Na Association (NFPA	e Survey was conducted by the ment of Public Safety - State ion. At the time of this survey, in Home was found not in ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection (A) Standard 101, Life Safety oter 19 Existing Health Care.				•	
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	N THE PLAN OF OR THE FIRE SAFETY			EPOC		
	Health Care Fire In State Fire Marshal 445 Minnesota St. St Paul, MN 5510	l Division , Suite 145					AVO DATE
		IDED/CLIDDLIED DEDDECENTATIVE'S SIG	MATURE		TITLE		(X6) DATE

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

TITLE

Electronically Signed

12/04/2015

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

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245338	B. WING _		11/	03/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 LUTHER PLACE ALBERT LEA, MN 56007	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa	age 1	K 00	00			
	Angela.Kappenma	itney@state.mn.us> and	×				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	to correct the defic	•					
	3. The name and/oresponsible for cor	roposed, completion date. or title of the person rection and monitoring to ence of the deficiency.				100	
	constructed at 4 di building is a 3 story in 1960. It was de construction. In 19 added to the north was determined to constructed to the determined to be of 1980, a 2 story add Annex and was de Because the origin meet the construction	ferent times. The original y building and was constructed termined to be of Type II(222) 64, a 2 story addition was east and southeast wings that be of Type II(222) 67, a 2 story addition was North and South that was of Type II(222) construction. In dition was added to the South the termined to be Type II (111). In all building and the 3 additions tion type allowed for existing ity was surveyed as a Type			** ** <u>*</u>		

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED	
		245338	B. WING		11/0	/03/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000 K 062 SS=D	II(111) building. The facility is fully a alarm system with and spaces open to monitored for autonotification. The facility has a consult of the requirement and NOT MET as evident NFPA 101 LIFE SAR Required automatic continuously maint condition and are in the requirement and second the requirement and	sprinkled . The facility has a fire full corridor smoke detection to the corridors that is matic fire department apacity of 170 beds and had a se time of the survey.	K O			12/7/15	
	Based on record realled to properly measurement accordance (2000 edition and Chapter 4, Se (1998 edition). In a practice could advistaff and visitors. FINDINGS INCLU On 11/03/2015 bet	is not met as evidenced by: eview and interview, the facility naintain the fire sprinkler nce with NFPA 101 Life Safety n), Chapter 19, Section 19.7.6 ction 4.6.12 and NFPA 25 a fire emergency, this deficient ersely affect 8 of 8 patients, DE: ween 8:00 AM and 11:00 AM, available records, it was		K062 Olympic Fire was contacted to the annual sprinkler flow test. test will be completed on Dece 2015. Olympic Fire will also instruct maintenance staff on how to concern the flow test will be complete year by Olympic Fire, and quality John smaintenance staff. The Environmental Services I keep a record of, and monitor	The flow ember 7, St. John sonduct d once per enterly by St. Director will		

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

Facility ID: 00138

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				ND NO.	0930-0391
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
١			245338	B, WING			11/0	3/2015
ŀ	NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ST JOHN	S LUTHERAN HOME	:			D1 LUTHER PLACE LBERT LEA, MN 56007		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 062	fire sprinkler system during the previous designed to test wat pressure switches, required devices of deficient practice was	uired quarterly flow tests of the m had not been conducted syear. Quarterly flow tests are ater flow alarm devices, water motor gongs and other f a fire sprinkler system. This was not in conformance with tion) Chapter 2, Section 2-3	K	062	in order to assure compliance.		10.
	K 154 SS=D	Engineer (PM). NFPA 101 LIFE SA Where a required a out of service for n period, the authorit and the building is watch system is pr unprotected by the	onfirmed with the Building AFETY CODE STANDARD automatic sprinkler system is nore than 4 hours in a 24-hour ty having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1	K	154			11/30/15
		Where a required out of service for n period, the authoriand the building is watch system is prunprotected by the system has been run on facility tour bet	is not met as evidenced by: automatic sprinkler system is nore than 4 hours in a 24-hour ty having jurisdiction is notified, evacuated or an approved fire rovided for all parties left e shutdown until the sprinkler returned to service. 9.7.6.1 ween 08:00 AM and 11:00 AM servation and documentation			K154 A policy and procedure specific to a Automatic Sprinkler System was won 11/30/15 that addresses St. Joh Plan of Action in the event that the Automatic Sprinkler System is out service for more than 4 hours in a period. The procedure includes notification State Fire Marshal Office and the I Fire Department.	rritten nn⊡s of 24-hour n to the	

Event ID: 5AKR21

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				TVID IVO.	0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245338	B. WING			11/03/2015	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		:			01 LUTHER PLACE		
STJOH	NS LUTHERAN HOME			Α	LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICLE DEFICIENCY)) BE	(X5) COMPLETION DATE
K 154 K 155 SS=D	plan for the out of s sprinkler system. This deficient prace Facility Maintenand discovery. NFPA 101 LIFE SA Where a required service for more that the authority having building is evacuate provided for all par	that there was not a single service plan for the fire tice was confirmed by the ce Director (PM) at the time of AFETY CODE STANDARD fire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been	к	154	The plan is located in the Environr Services Director soffice and in the Emergency Manuals that are located each of the nurse stations. The Administrator will monitor for compliance, and will make change Policy or Procedure when recomme by the State Fire Marshal Office.	the ted at ongoing es to the	11/30/15
	Where a required service for more the authority havin building is evacuat provided for all particular provided for all particular to service. On facility tour bet on 11/03/2015, observiewed revealed plan for the out of system.	is not met as evidenced by: fire alarm system is out of nan 4 hours in a 24-hour period, g jurisdiction is notified, and the red or an approved fire watch is rties left unprotected by the fire alarm system has been e. 9.6.1.8 ween 08:00 AM and 11:00 AM servation and documentation that there was not a single service plan for the fire alarm			K155 The policy and procedure was upon 11/30/15 that addresses St. Johns of Action in the event that the Fire System is out of service for more hours in a 24-hour period. The procedure includes notification State Fire Marshal Office and the Fire Department. The plan is located in the Environ Services Director is office and in Emergency Manuals that are located and the Includes of the nurse is stations. The Administrator will monitor for compliance, and will make chang Policy or Procedure when recommends.	Is Plan Alarm than 4 on to the local mental the local at ongoing es to the	

Event ID: 5AKR21

PRINTED: 12/09/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245338	B, WING			11/0	3/2015
	PROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE 01 LUTHER PLACE LBERT LEA, MN 56007	1110	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 155	Continued From pa Facility Maintenand discovery.	age 5 ce Director (PM) at the time of	K	155	by the State Fire Marshal Office.		
					10		5
							1 2
		ę.					



Protecting, Maintaining and Improving the Health of Minnesotans

7013 3020 0001 8869 0404 Electronically submitted November 20, 2015

Mr. Scot Spates, Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5338026

Dear Mr. Spates:

The above facility was surveyed on November 2, 2015 through November 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary

St Johns Lutheran Home November 20, 2015 Page 2

Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/05/2015	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE	•	
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/04/15

STATE FORM 6899 If continuation sheet 1 of 33 5AKR11

TITLE

(X6) DATE

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		DATE SURVEY COMPLETED	
		00138	B. WING		11/05/	2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	117007	2010	
			ER PLACE	STATE, ZII OODE			
ST JOH	NS LUTHERAN HOME		EA, MN 56	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Department of Hearyou electronically. Is necessary for Starenter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Departm. On November 2nd surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed. Minnesota Departmente State Licensing federal software. Ta assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of completed in the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of completed in the statement, evidence by." Follow are the Suggested in the Sugges	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the ent of Health. 3rd, 4th and 5th 2015, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ed. Intent of Health is documenting Correction Orders using an umbers have been ota state statutes/rules for comply and the ent of Deficiencies column to Comply" portion of the ent of Deficiencies column to Comply" portion of the ent of Deficiencies column to Comply" portion of the ent violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period Form Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF THIS O DN FOR		

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING.	·			
		00138	B. WING		11/0	5/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST JOHN	IS LUTHERAN HOME		IER PLACE LEA, MN 56	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	THIS WILL APPEA	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			12/13/15	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).					
	by: Based on document facility failed to ensideveloped for use of	ent is not met as evidenced at review and interview the ure a plan of care was of blood thinning medication sidents reviewed for eations.		Corrected			
	Findings include:						
	identified R171's ac included a history of stage 3 and vitaminidentified was a dia vein thrombosis (D'	dry Client Diagnosis Report dritting diagnosis (11/4/14) of falls, chronic kidney disease in B12 deficiency anemia. Also gnosis dated 4/8/15 for deep VT) LE (lower extremity).					
		mum Data Set (MDS) dated Brief Interview for Mental					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
	PROVIDER OR SUPPLIER	901 LUTH	DRESS, CITY, SER PLACE LEA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Status score of 4 in impairment. The MI required extensive a perform activities of falls since prior ass. R171's physician or 10/31/15 included 0 milligrams (mg) dainot eating 2 meals/note dated 8/14/15 of unprovoked DVT Coumadin. The phythis was unprovoke recommended for lioutweigh the benefit R171's care plan dafor falls with major in skin integrity (bru propels wheelchair, bars/railings, may be bars/railings, m	dicative of severe cognitive DS further identified R171 assist of one person to f daily living and had 2 or more essment. Iders for 10/7/15 through Coumadin (anticoagulant) 4.5 ly at bedtime for DVT. Hold if day. A physician progress identified R171 had a history for which she receives ysician stated, "Given the fact d, Coumadin was fe unless the risks of bleeding its." ated 10/20/15, included at risk njury and at risk for alteration ising/skin tears) related to	2 560			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00138	B. WING		11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	"instruct patient abore minimize risk of ble symptoms of bleed other drugs, diets a increase the internatest that measures measure Coumadir "observe caution wito elderly patients in physical condition whemorrhage is press." The facility policy A reviewed 8/2014, in monitored for any a bruising and MD/NI practitioner) to be not suggested by the policies and prodevelopment of car could provide educate facility could development of car found in the policies and prodevelopment of car could provide educate facility could development of car findings to the Quality of the policies and prodevelopment of car could provide educate facility could development of car findings to the Quality of the policies and prodevelopment of car could provide educate facility could development of car could provide educate facili	major bleeding or t included directions to but prevention measures to eding and report signs and ing." Package insert indicated and other factors could ational normalized ratio (lab clotting time of blood used to a doses). The insert included, th administration of Coumadin any situation or with any where added risk of sent." Inticoagulant Therapy Policy lentified, "Resident is dverse signs of bleeding or c (medical doctor/nurse	2 560			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			12/13/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME	ı	IER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	by: Based on interview facility failed to folloreporting bruising for R139) reviewed for conditions and for proceeding for 2 of 2 residents positioning needs.	ent is not met as evidenced and document review the bw the plan of care for or 2 of 3 residents (R148, non pressure related skin proper wheelchair positioning (153, 136) reviewed with		Corrected		
	Findings include:					
	her room sitting up was noted to have located on her right circular bruise was yellow/purple bruise arm biceps area a purple/yellow bruise circular shape. The as if they could be didn't know how sh	p.m. R148 was observed in right in the wheelchair. R148 a large circular purple bruise mid forearm. Above the noted a V shaped lighter e. Also noted on R148's left cluster of 4 smaller circular es which were in a semile 4 smaller bruises appeared finger marks. R148 stated she e got the bruises but indicated 148 had geri sleeves on both				
	an alteration in bath interventions include problems and decli- altered skin integrit	d October 2015, identified: (1) ning/grooming/dressing with ling: Observe and report skin ne to nurse and (2) at risk for y with interventions including: own with cares/bath.				
	nurse (RN) on the p through 9/30/15, id	entered by the registered ohysician orders dated 9/1/15 entified: bruises easily but skin ent record dated 11/1/5 to				

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AND BLAN OF CORRECTION INDENTIFICATION NUMBER:	(2) MULTIPLE CONSTRUCTION . BUILDING:	(X3) DATE SURVEY COMPLETED
00138 B.	. WING	11/05/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRE	ESS, CITY, STATE, ZIP CODE	
ST JOHNS LUTHERAN HOME 901 LUTHER ALBERT LEA	_	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE
2 565 Continued From page 6 11/30/15, indicated- skin was to be checked on bath day and bruise, rash, open area etc. should be documented. The treatment record had documentation indicating R148 received a bath on 11/2/15. The identified bruised areas were noted on 11/4/15, at 1:49 p.m. with clinical manager (CM)-B. CM-B stated at this time the bruises located on the top of R148 left arm appeared like finger marks. When questioned about rough treatment, R148 stated, "no". CM-B verified the bruises had not been reported and subsequently the care plan had not been followed. She stated the bruising should have been identified with cares and reported to the nurse. On 11/5/15, at 3:21 p.m. the bruises were documented in the chart with measurements of the right forearm as 2.1 cm x 1.4 cm and 4.2 cm x 1.4 cm. Bruises to the left upper extremity measured 1.7 cm x 1.3 cm, 0.3 cm in diameter and 1.2 cm x 0.5 cm. On 11/3/2015, at 12:22 p.m. R139 was observed sitting in the dayroom in his wheelchair. with a noted dark purple, crescent shaped bruise to the right forearm above the wrist. Also noted was a dime size purple/yellow bruise to the inner forearm below the antecubital space. R139 was unable to verbalize where/how the bruises occurred. When asked whether anyone hurt him he replied, "well I have 11 of them over there." Review of the care plan dated September 2015, identified: (1) at risk for alteration in skin integrity, bruising, skin tears related to a history of physical aggressiveness, and bumps into doors and object; interventions included: Monitor for	2 565	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST JOH	NS LUTHERAN HOME		ER PLACE LEA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	(2) alteration in bath with interventions in skin problems. When interviewed on ursing assistant (Nassisted R139 with noticed the bruises. expected to report to conditions/bruising. Interview with CM-Everified R139's bruidentified, reported CM-B verified the cimplemented as writed as	ning, grooming and dressing acluding: Observe and report on 11/4/15, at 12:30 p.m. IA)-D confirmed she had morning cares and had not NA-D stated staff were to the nurse when skin were discovered. Son 11/4/15, at 1:49 p.m. ising should have been to the nurse and monitored. are plan had not been	2 565			

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 a.m., NA-B was observed to move R153 in his w/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past. R153's care plan dated 9/22/15 included a	STATEMEN	TO DEPARTMENT OF THE OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER ST JOHNS LUTHERAN HOME (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 a.m., NA-B was observed to move R153 in his w/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past.			00138		B. WING		5/2015
ST JOHNS LUTHERAN HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 a.m., NA-B was observed to move R153 in his w/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past.	NAME OF					1 11/0	5/2015
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 a.m., NA-B was observed to move R153 in his w/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past.			901 I IITH	, ,	STATE, ZIF GODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 a.m., NA-B was observed to move R153 in his W/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past.	ST JOHNS LUTHERAN HOME ALBERT				007		
a.m., NA-B was observed to move R153 in his w/c closer to the window. NA-B adjusted and locked R153's w/c back to a semi-reclined position. R153's legs/feet were observed to be held upward stretched out in front of him. When NA-B was questioned whether R153 had ever utilized a leg/footrest for his w/c, NA-B could not recall ever having a footrest. NA-B indicated R153 always tended to hold his legs out in this fashion, or crossed his legs, or pulled them upward by the wheel of the chair but didn't dangle his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
problem of impaired physical mobility r/t cognitive and physical impairment. Intervention dated 2/25/15 included: "Uses w/c/Rock-n-Go to move to/from destination on/off unit with asst (assist) of 1; Encourage to propel self short distances with cues; Monitor positioning prn (as needed); and Monitor for changes in abilities." When interviewed on 11/5/15, at approximately 2:05 p.m. CM-B and surveyor observed R153 seated in his w/c in the 1st floor NE solarium. R153 was finishing his lunch with assistance from NA-B. R153's w/c was in the upright position, the balls of R153's feet only were touching the floor. NA-B confirmed that R153 is reclined intermittently while in his w/c and during those times, his feet do not touch the floor. CM-B verified R153's chair was in need of a leg/footrest for support/proper positioning, especially when in a reclined position. R136's care plan dated 10/16/15 included a problem of impaired physical mobility r/t physical	2 565	a.m., NA-B was obs w/c closer to the will locked R153's w/c k position. R153's leg held upward stretch NA-B was question utilized a leg/footres recall ever having a R153 always tender fashion, or crossed upward by the wheeh is legs. NA-B furth longer propel his w/t the ability in the pass R153's care plan daproblem of impaired and physical impair 2/25/15 included: "Uto/from destination 1; Encourage to procues; Monitor posit Monitor for changes When interviewed of 2:05 p.m. CM-B and seated in his w/c in R153 was finishing NA-B. R153's w/c which is feet do not werified R153's charter intermittently while it times, his feet do not werified R153's charter plan days care plan d	served to move R153 in his ndow. NA-B adjusted and back to a semi-reclined ps/feet were observed to be ned out in front of him. When ed whether R153 had ever st for his w/c, NA-B could not a footrest. NA-B indicated d to hold his legs out in this his legs, or pulled them el of the chair but didn't dangle ner verified R153 could not do independently though had st. ated 9/22/15 included a diphysical mobility r/t cognitive ment. Intervention dated Jses w/c/Rock-n-Go to move on/off unit with asst (assist) of opel self short distances with tioning prn (as needed); and is in abilities." on 11/5/15, at approximately disurveyor observed R153 the 1st floor NE solarium. his lunch with assistance from was in the upright position, the only were touching the floor. at R153 is reclined in his w/c and during those of touch the floor. CM-B ir was in need of a leg/footrest positioning, especially when in ated 10/16/15 included a	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMPLETED	
		00138	B. WING		11/0	5/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST JOH	NS LUTHERAN HOME		IER PLACE LEA, MN 56	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 565	4/30/15 included: "L LOCOMOTION on/ Monitor correct pos On 11/05/15, at 4:5 her room seated in was locked in a sen residents legs and tapproximately 10-15 footrests attached tupward. On 11/05/15, at 4:5 observed R136 in hid dangling. CM-B co locked semi-recline resident's feet coulc put the footrest on I position and confirm a down position R1 the footrests when positioned correctly improper positioning. On 11/05/15, at 5:0 observed R136 sea feet dangling. DON dangling and that it SUGGESTED MET The director of nursidevelop, review, an procedures to ensu plans according to the needs. The director could educate all agand procedures. The	Jses w/c or Rock N Go for off the unit with assist of 1. itioning. Report changes" 0 p.m. R136 was observed in her Rock-n-go w/c. The w/c ni-reclined position; the feet were observed dangling 2 inches from the floor. The othe chair were raised 5 p.m. CM-B and surveyor the rw/c in room with feet nfirmed R136's chair was in a d position and that the d not touch the floor. CM-B R136's chair in the downward ned that even when placed in 36's feet could still not touch reclined and was not c. CM-B confirmed the g for R136. 10 p.m. the DON and surveyor ted in her room in w/c with I confirmed R136's feet were was an issue. 14 HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re the facility develops care the residents individualized of nursing (DON) or designee opropriate staff on the policies are director of nursing (DON) or elop monitoring systems to	2 565				

Minnesota Department of Health

-	AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION (X3) DATE (COMPL		
		00138	B. WING		11/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			12/13/15
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review the facility fa bruising for 2 of 3 (I reviewed for non pr and failed to provide support positioning	ent is not met as evidenced on, interview, and document illed to identify and monitor R148, R139) residents essure related skin conditions, e proper wheelchair and foot for 2 of 2 residents (R153, h positioning needs.		Corrected		
	Findings include:					
	her room sitting upr was noted to have a located on her right circular bruise was	p.m. R148 was observed in ight in the wheelchair. R148 a large circular purple bruise mid forearm. Above the noted a V shaped lighter e. Also noted on R148's left				

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	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHNS LUTHERAN HOME		ER PLACE .EA, MN 560	007		
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didn't know how she got no one hurt her. R148 h arms. Review of the 9/29/15, a (MDS) indicated a Brief I Status score of 5 which i cognitive impairment and needed with activities of The progress note enternurse (RN) on the physic through 9/30/15, identificintact. The treatment red 11/30/15 indicated, Skin bath day and bruise, rash be documented. The treidentified R148 had her to the care plan dated Oct an alteration in bathing/g interventions including: problems and decline to altered skin integrity with Monitor for breakdown where the care plan through the care plan dated Oct an alteration in bathing/g interventions including: problems and decline to altered skin integrity with Monitor for breakdown where the care plan through the care plan dated Oct an alteration in bathing/g interventions including: problems and decline to altered skin integrity with Monitor for breakdown where the care plan dated of the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated of the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and altered skin integrity with Monitor for breakdown where the care plan dated Oct and the care pla	er of 4 smaller circular nich were in a semi maller bruises appeared marks. R148 stated she the bruises but indicated had geri sleeves on both annual Minimum Data Set Interview for Mental is indicative of severe development (ADL's). The device of severe development (ADL's) and the development of	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOH	NS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	documented in the the right forearm as x 1.4 cm. Bruises t measured 1.7 cm x and 1.2 cm x 0.5 cm. On 11/03/2015, at 1 sitting in the dayroonoted dark purple, oright forearm above dime size purple/ye forearm below the aunable to verbalize occurred. When as he replied, "well I has the replied, "w	chart with measurements of s 2.1 cm x 1.4 cm and 4.2 cm o the left upper extremity 1.3 cm, 0.3 cm in diameter m. 2:22 p.m. R139 was observed m in his wheelchair. with a crescent shaped bruise to the enth wrist. Also noted was a llow bruise to the inner antecubital space. R139 was where/how the bruises ked whether anyone hurt him ave 11 of them over there." dated 9/2/15, identified a erately impaired cognition, and extensive assistance Review of the treatment of 11/30/15, identified skin ay and document on any area etc. R139 had falls on 10/22/15 and 10/29/15. plan dated September 2015, k for alteration in skin integrity, related to a history of physical dobumps into doors and included: Monitor for es/bath. Also identified was: hing, grooming and dressing including: Observe and report	2 830			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE	207		
	OLIMANA DV. OTA		LEA, MN 560		ON	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	conditions/bruising	were discovered.				
		3 on 11/4/15, at 1:49 p.m. should have been identified, se and monitored.				
	seated in a Rock-n- floor northeast (NE the room. R153's v semi-reclined positi hold his legs/feet up were no leg/foot su R153 was observed minutes. R153's le move frequently fro crossing his ankles his legs, and trying wheel of the w/c. V	23 p.m. R153 was observed go wheelchair (w/c) in the 1st solarium; R153 was alone in w/c was observed locked in a on; R153 was observed to and stretched outward; there pports observed on the w/c. If for approximately 15-20 gs feet were observed to m a stretched out position, to bending his knees, dangling to place his left leg on the when R153 extended his left yield hoor.				
	On 11/04/15, at 9:1 the 1st floor NE sol (NA)-B for the brea in his Rock-n-go w/balls of his feet wer There were no foot w/c. NA-B assisted w/c remained in the a.m., NA-B was obs w/c closer to the wi locked R153's w/c loser to the wi locked R153's w/c loser to the willocked R153's legheld upward stretch NA-B was question utilized a leg/footrer recall ever having a R153 always tende fashion, or crossed	0 a.m. R153 was assisted to arium by nursing assistant kfast meal. R153 was seated c in an upright position, the e observed to touch the floor. nor leg rests observed on the I R153 with eating while his upright position. At 9:56 served to move R153 in his ndow. NA-B adjusted and pack to a semi-reclined pack to a semi				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE ALBERT LEA, MN 56007 CALL D. PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCY SIZEMAN SOURCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 14 his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past. R153's annual Minimum Data Set (MDS) dated 99/315, indicated extensive assistance from staff with bed mobility, transfer, eating, personal hygiene, locomotion on unit, toilet use, and dressing. The MDS further indicated short and long term memory problems and severe impairment related to (r/t) daily decision making. Review of the care plan dated September 2015, identified: (1) at risk for alteration in skin integrity, bruising, skin tears related to a history of physical aggressiveness, and bumps into doors and object; interventions included: Monitor for breakdown with cares/bath. Also identified was: (2) alteration in bathing, grooming and dressing with interventions including: Observe and report skin problems. Review of R153's medical record did not include an assessment by occupational therapy (OT) for w/c positioning. When interviewed on 11/5/15, at 1:59 p.m. clinical manager (CM)-B confirmed the OT did not evaluate R153 for w/c positioning. CM-B stated the facility requested an order for the Rock-n-go w/c as it would be more comfortable and would			00138	B. WING		11/0	05/2015	
XA-JID DATE DATE	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG	ST JOHN	NS LUTHERAN HOME		_	007			
his legs. NA-B further verified R153 could not longer propel his w/c independently though had the ability in the past. R153's annual Minimum Data Set (MDS) dated 9/9/15, indicated extensive assistance from staff with bed mobility, transfer, eating, personal hygiene, locomotion on unit, toilet use, and dressing. The MDS further indicated short and long term memory problems and severe impairment related to (r/t) daily decision making. Review of the care plan dated September 2015, identified: (1) at risk for alteration in skin integrity, bruising, skin tears related to a history of physical aggressiveness, and bumps into doors and object; interventions included: Monitor for breakdown with cares/bath. Also identified was: (2) alteration in bathing, grooming and dressing with interventions including: Observe and report skin problems. Review of R153's medical record did not include an assessment by occupational therapy (OT) for w/c positioning. When interviewed on 11/5/15, at 1:59 p.m. clinical manager (CM)-B confirmed the OT did not evaluate R153 for w/c positioning. CM-B stated the facility requested an order for the Rock-n-go w/c as it would be more comfortable and would	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE	
p.m. CM-B and surveyor observed R153 seated in his w/c in the 1st floor NE solarium. R153 was finishing his lunch with assistance from NA-B. R153's w/c was in the upright position, only the balls of R153's feet were touching the floor. NA-B confirmed she would recline the resident at times in his w/c and further confirmed that when she does this his feet cannot touch the floor.	2 830	his legs. NA-B furth longer propel his w/the ability in the pass R153's annual Minit 9/9/15, indicated exwith bed mobility, tr. hygiene, locomotion dressing. The MDS long term memory primpairment related Review of the care identified: (1) at ris bruising, skin tears aggressiveness, an object; interventions breakdown with car (2) alteration in bath with interventions in skin problems. Review of R153's man assessment by w/c positioning. When interviewed of manager (CM)-B confirmed show the facility requeste w/c as it would be not decrease the risk for p.m. CM-B and sum in his w/c in the 1st finishing his lunch write R153's w/c was in the balls of R153's feet NA-B confirmed should be not confir	ner verified R153 could not /c independently though had st. mum Data Set (MDS) dated tensive assistance from staff ansfer, eating, personal non unit, toilet use, and further indicated short and problems and severe to (r/t) daily decision making. plan dated September 2015, k for alteration in skin integrity, related to a history of physical dobumps into doors and sincluded: Monitor for es/bath. Also identified was: ning, grooming and dressing including: Observe and report in the dical record did not include occupational therapy (OT) for in 11/5/15, at 1:59 p.m. clinical profirmed the OT did not w/c positioning. CM-B stated do an order for the Rock-n-go more comfortable and would or falls. At approximately 2:05 veyor observed R153 seated floor NE solarium. R153 was with assistance from NA-B. he upright position, only the were touching the floor. e would recline the resident at a further confirmed that when					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00138	B. WING		11/0	5/2015
	PROVIDER OR SUPPLIER	901 LUTH	DRESS, CITY, S IER PLACE LEA, MN 560	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	CM-B verified R153 leg/footrest and furt good for the resider reclined position with When interviewed of director of nursing (OT had evaluated Fand further stated it they would request confirm or deny who positioning when releg/footrests as this resident. R136's quarterly MI total dependence woon unit, and extensimobility, dressing, whygiene. The MDS long term memory impairment related R136's care plan daproblem of impaired and cognitive impair 4/30/15 included: "LLOCOMOTION on/Monitor correct poston of the company	B's chair was in need of a cher confirmed it would not be not to be positioned in a thout one. In 11/05/15, at 4:21 p.m. the (DON) stated being unaware if R153 r/t wheelchair positioning was individualized as to when this. The DON could not either the resident's w/c clined was appropriate without was individualized with each as individualized with each of the transfers and locomotion was individualized with bed eating, toilet use, and personal further indicated short and problems and severe to (r/t) daily decision making. Intervention dated Jess w/c or Rock N Go for off the unit with assist of 1. itioning. Report changes of p.m. R136 was observed in her Rock N Go w/c. The w/c mi-reclined position; the feet were observed dangling 2 inches from the floor. The othe chair were raised	2 830			
		5 p.m. CM-B and surveyor er w/c in room with feet				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
	PROVIDER OR SUPPLIER	901 I UTH	DRESS, CITY, S	STATE, ZIP CODE		
STJOHN	IS LUTHERAN HOME	ALBERT L	EA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	dangling. CM-B collocked semi-recline resident's feet could put the footrest on a position and confirm down the resident's footrests when recli improper positioning would notify OT for On 11/05/15, at 5:00 observed R136 sea w/c with feet dangling as SUGGESTED MET Director of Nursing polices and procedimonitoring non-presand related to moni wheelchairs/position or her designee coupolicies and proced develop a monitoring compliance and rep Assurance Commit	Infirmed R136's chair was in a d position and that the d not touch the floor. CM-B R136's chair in the downward ned that even when adjusted feet could still not touch the ned. CM-B confirmed the g for R136 and stated she further evaluation. O p.m. the DON and surveyor ted in her room in ng. DON confirmed R136's and that it was an issue. CHOD OF CORRECTION: The or her designee could develop ures regarding assessing and source related skin conditions toring resident ning. The Director of Nursing all deducate staff on the ures. The facility could ag system to ensure ongoing port the findings to the Qualify	2 830			
21015	Requirements- Sar	•	21015			12/13/15
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00138	B. WING		11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		IER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	This MN Requirements: Based on observation review the facility factor (can opener) utilized clean and sanitary opotential to affect all facility who consum kitchen. Findings include: The initial kitchen to at 11:45 am. with the food service manage tour the following sate The electric can oppreparation process service counter. A substance was evide and on the back side thick, black oily subfront surface of the heavily soiled black and around the cuttopener located on the bove findings were when the kitchen of was reviewed, it was cleaning the can open surface of dietacleaning schedule for the control of the contro	ent is not met as evidenced on, interview, and document illed to maintain equipment d in food preparation in a condition. This had the ill 134 residents residing in the ed foods served from the our was conducted on 11/2/15, he facility dietician (RD) and per (DM). During the initial anitary concern was noted: ener utilized in various food ses was located on the food thick buildup of a black oily lent in the area located under le of the cutting blade. This stance was dripping down the can opener. In addition, a substance was evident on ing blade of the manual can he same counter. 11/2/15, at 11:45 a.m. the everified by the RD and DM. leaning schedule document s noted a schedule for	21015	Corrected		
	also provide educat	ctor of dietary services could ion to dietary staff on the porne illness through good				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00138	B. WING	B. WING		5/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
21015	Continued From pa	ge 18	21015				
	sanitary practices.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program		21375			12/13/15	
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper infection control procedures were implemented for 1 of 1 resident (R92) who required special contact precautions.			Corrected			
	Findings include:						
	personal protective gloves and gowns v Rubbermaid contain R92's room. There the door of this roor information in the th	d on 11/3/15, at 5:42 p.m. that equipment (PPE) including was stored in a three drawer ner located outside the door of e was no magnet located on m nor was there any aree drawer container related act precautions required of					
	nursing community week R92 was cont didn't know with wh	on 11/3/15, at 5:45 p.m. assistant (NCA)-A stated last agious with something but at; however, indicated a staff when R92 was assisted to the					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		IER PLACE LEA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 19	21375			
		added since there remained or, R92 must still be				
	stated R92 had Clo they couldn't post s what was going on information during i CM-A stated they ir gloves, gowns, perf R92 to wash his ha CM-A also indicated	p.m. clinical manager (CM)-A stridium difficile (C-diff) and igns alerting staff and visitors with R92, so staff pass the report to the oncoming staff. Instruct oncoming staff to wear form handwashing and instruct inds prior to leaving the room. If they try to catch family form them about the special is.				
	When interviewed on 11/4/15, at 10:07 a.m. nursing assistant (NA)-A stated she was unaware of the special precautions required for R92 as she hasn't worked since last weekend and doesn't work very often.					
	registered nurse (R resident requires spis alerted by placing door. RN-A stated information in the discontainer which expressions the NA's communic documentation/noti who require special explained that nurs	on 11/5/15, at 10:30 a.m. (N)-A stated that when a pecial contact precautions staff a magnet on the resident's she also places printed rawer of the Rubbermaid plains to staff the type of a required. RN-A also stated eation book should include fication related to residents I contact precautions. RN-A ing staff should review the ok every time they work.				
	RN-A verified there identifying that spec	wed on 11/5/15, at 12:04 p.m. was no magnet on R92's door cial contact precautions were sere printed information				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00138	B. WING		11/0	11/05/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CT IOUR	IC LUTUEDAN HOME	901 I UTH	ER PLACE				
ST JOH	NS LUTHERAN HOME	ALBERT I	LEA, MN 560	007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 20	21375				
	agreed that family a to any special conta system evident whi nursing staff prior to room.	obermaid container. RN-A also and/or visitors were not alerted act precautions nor was ch alerted them to check with their visit and/or entering the					
	When interviewed on 11/5/15, at 4:01 p.m. CM-A verified the Certified Nursing Assistant initial 24 hour care guide for R92 included in the nursing assistant communication book did not have documentation indicating R92 had C-diff nor did it indicate the necessary infection control procedures/contact precautions to implement when providing cares. The facility procedure to reduce the risk of transmission between residents, personnel and visitors had not been implemented.						
	Precautions, review purpose as: To red disease transmissic protect personnel a recognized sources identified the follow Precautions will be Standard Precaution suspected to be informationally suspected to be informationally or contact religionally or contact religionall	and Transmission Based yed 9/08, identified the luce the risk of infectious on between residents and to and visitors from exposure to so finfection. The policy also ing: *Transmission Based instituted, in addition to ans, for residents known or ected or colonized with aisms spread by airborne, routes of transmission. Management as: *Visitors will practice of Standard isolation precautions are in expected to wash hands leaving the isolation room.					
		and director of nursing could afection control policies and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00138	B. WING		11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21375	Continued From pa	ge 21	21375			
	necessary to the im notification of visito are necessary. The develop an audit to implemented per fa	g staff could be educated as apportance of hand hygiene and rs when special precautions DON or designee, could ol to ensure policies are acility policy.				
	(21) days.					
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			12/13/15
	 (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. 					
	by:	ent is not met as evidenced and document review, the		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00138	B. WING		11/0	5/2015
NAME OF PROVIDER OR SUPPLIER ST JOHNS LUTHERAN HOME	901 LUTH	DRESS, CITY, S ER PLACE LEA, MN 560	TATE, ZIP CODE		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL (1997)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
test (TST) per curre and Prevention (CDr facility policy for 3 of Tuberculosis (TB) P Findings include: Dietary aide (DA)-A and had the tuberculous and first TST application of evidence of a second secon	orm a 2-Step tuberculin skin nt Center for Disease Control C) recommendations and per f 5 employees reviewed for revention and Control. had a hire date of 8/28/15, llosis screening on 9/1/15, ation on 9/2/15. There was cond TST application. IA)-E had a hire date of tuberculosis screening and on 9/9/15. There was no	21426			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
	PROVIDER OR SUPPLIER	901 LUTH	DRESS, CITY, S ER PLACE LEA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21426 21695	must receive a two SUGGESTED MET director of nursing of policies and proced The director of nurs employees regardir facility infection con nursing could monit and TST for employ TIME PERIOD FOR (21) days. MN Rule 4658.1418	step tuberculin skin test. CHOD OF CORRECTION: The could review tuberculosis ures to ensure compliance. sing could educate all ing TB education and the trol plan. The director of cor compliance for screening wees and residents. CORRECTION: Twenty-one	21426			12/13/15
	provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements by: Based on observation review the facility factorior equipment in a clear promote sanitation kitchen. This practicall 134 residents which kitchen. Findings include: The initial kitchen to	eping. A nursing home must ing and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on, interview and document alled to maintain kitchen and sanitary manner to and food safety in the dietary tice had the potential to affect no received food from the		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	
AND I LAIN	OF CONTLCTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVII	LLILD
		!				
		00138	B. WING		11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		901 I IITH	ER PLACE	,		
ST JOHN	NS LUTHERAN HOME	i	LEA, MN 56	007		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
21695	Continued From pa	ge 24	21695			
	food service manag	ger (DM). During the initial				
	tour the following sa	anitary concerns were noted:				
	. _					
		age freezer in the kitchen was				
		xcessive food and debris				
		led) on the bottom of the				
	inside of the freezer. Foods items stored in the freezer were stored in direct contact with the food					
	debris and particles in the base of the freezer.					
		sion feed lines under the cook				
		oted to have a heavy buildup of				
		he feed lines were coated with				
		nging from the lines. At the				
		tion, staff were cooking three urst directly under these				
	heavily soiled feed l					
	Ticavily solica icca i					
	3. The wall on the le	eft side of the cook stove				
	adjacent to the cool	k stove hood was also noted				
		ild up of dust and a coating of				
		ppression system feed lines				
		vertical were also noted to be				
	heavily soiled.					
	4 The large walk-in	n storage freezer in the				
		ed to have boxes of chicken				
		rectly on the floor. The DM				
		had been delivered on the				
	previous Friday and	d had been left on the dirty				
		ce delivery. It was noted the				
		n the freezer was already filled				
		DM verified the dietary				
		rd was to store items on				
	sneives and not on	the floor in the walk-in freezer.				
	During the tour on 1	11/2/15, at 11:45 a.m. all of the				
		e verified by the RD and DM.				
		hood over the cook stove was				

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routinely cleaned on a schedule but the feed lines

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			74 5512511td:			
		00138	B. WING	 	11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE -EA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	as part of routine of cleaning list failed to the upright freezer. That the back wall a hood was to be clean SUGGESTED MET. The dietary manages schedule which inclinding the walk-i around the stove/ho conducted periodicassurance committed.	ge 25 ion system were not identified eaning. Review of the kitchen o identify cleaning the inside of The cleaning list identified djacent to the cook stove aned on a daily basis. THOD OF CORRECTION: er could develop a cleaning luded all areas of the kitchen, in freezers and the areas lood. An audit could be ally and report to the quality ee at the quarterly meetings.	21695			
21942	Resident and Famil Resident advisory of boarding care home advisory council an fewer than three per participating. If one function, the nursin home shall docume council or councils year. This subdivision residents and famil 144.651, subdivision This MN Requirements. This MN Requirements.	council. Each nursing home or e shall establish a resident d a family council, unless resons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ies provided by section	21942	Corrected		12/13/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00138	B. WING	·····	11/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From pa	ge 26	21942			
	council during the p	ast calendar year.				
	Findings include:					
	activity director (AD family council was reported the last family council was reported the last family council further explained the attended in the pass pass away, so a far AD stated she was on 11/17/15 and had or 5 family member unit and planned to stated she was not information to familif facility. AD verified	on 11/5/15, at 11:48 p.m. the) stated at the current time a non-existent. AD confirmed cil meeting was 3/6/14 and at all the family members who thad their resident/parent nily council no longer existed. planning on having a meeting dher staff submit names of 4 s who visit frequently on each invite those people. AD planning on sending the ies of all the residents in the no attempts to re-establish peen made since 3/6/14.				
	director of nursing (review or revise pol staff regarding form The DON could mo	HOD OF CORRECTION: The DON) and/or designee could icies, provide education for ulation of a family council. nitor to assure that all family the opportunity to attend a				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
23010	MN Rule 4658.4635 Construction	5 A Nurse Call System; New	23010			12/13/15
	communication sys from the resident ar required by this par	must be equipped with a tem designed to receive calls and nursing service areas t. The communication y powered, must be				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
ST JOHNS LUTHERAN HOME 901 LUTHI			DRESS, CITY, S ER PLACE LEA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	N SHOULD BE COMPL E APPROPRIATE DATI	
23010	connected to the er Nurse calls and em of being inactivated central annunciator door is not visible fr A. A nurse call resident's bed. Cal communication development of they are within react from a resident mustation, activate a libedroom, and active medication room, room, soiled utility resident of the provided at t	mergency power supply. ergency calls must be capable only at the points of origin. A must be provided where the om the nurses' station. must be provided for each I cords, buttons, or other rices must be placed where the of each resident. A call st register at the nurses' ght outside the resident ate a duty signal in the ourishment area, clean utility oom, and sterilizing room. In ng units, visible signal lights t corridor intersections. ent is not met as evidenced on, interview, and document tiled to ensure that 5 of 40 the property so that ans of contacting staff. ston on 11/3/15, at 12:28 p.m. toom 116) was observed the bathroom call light did not the property of the pathroom call light did not perviewed on 11/3/15, at 12:29 the bathroom call light had the bedroom call light had the bedroom call light had that morning and had been	23010	Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L COM		(X3) DATE	SURVEY LETED	
JUNE 1 EARLY OF GOTHLEGHOW		A. BUILDING:		OCIVII	LLILD	
00138			B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CT IOUN	IS LUTHERAN HOME	901 LUTH	ER PLACE			
31 JUH	NS LUTHERAN HOWE	ALBERT I	LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
23010	Continued From pa	ge 28	23010			
	activated. Upon puthe call light unit start call light did not regord the resident's root station, indicating the activated. Surveyord the call light was not LPN-C further verifical light had been a system routinely ale radios when resided LPN-C gave R142's passing nursing as she bring it to main	·				
	During an observation on 11/3/15, at 12:51 p.m. R106's (room 109) bedroom and bathroom call lights were tested/activated. Neither call light was functional.					
	R33's (room 124) b lights were tested a Nursing assistant (I the call lights were continued to test the	ion on 11/3/15, at 1:13 p.m. edroom and bathroom call and neither functioned. NA)-C was alerted and verified not functioning. NA-C e call lights and after several ghts eventually functioned and the system.				
	R75's (room 136) b and did not function surveyor that some becomes loose and into the call light bo	ion on 11/3/15, at 1:51 p.m. edroom call light was tested a. R75 indicated to the times the call light cord I needs to be pushed back up x unit. Subsequently, when d the cord into the box unit, ned properly.				

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	AND DUAN OF CODDECTION IDENTIFICATION NUMBER:				SURVEY
ST JOHNS LUTHERAN HOME 901 LUTHER PLACE ALBERT LEA, MN 56007 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) (X4) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		00138	B. WING	11/0	05/2015
ALBERT LEA, MN 56007 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PROVIDER'S PLAN OF CORRECTION (COMMENTAL COMMENTS) (X4) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X4) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X5) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X6) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X6) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X6) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X7) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X7) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X6) ID PREFIX TAGE (X7) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X7) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X7) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X7) ID PREFIX TAGE (X8) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X8) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X8) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X9) ID PROVIDER'S PLAN OF COMMENTS (X9) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X9) ID PROVIDER'S PLAN OF COMMENTS (X9) ID PROVIDER'S PLAN OF CORRECTION (COMMENTS) (X9) ID PROVIDER'S PLAN O	NAME OF PROVIDER OR SUF	UPPLIER STREET AD	RESS, CITY, STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMING TO THE APPROPRIATE DEFICIENCY)	ST JOHNS LUTHERAN	N HOME			
	PREFIX (EACH DEFI	EFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE AT CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
On 11/4/15, at 8:30 a.m. R142 was observed seated in reciliner in room watching television. When questioned by the surveyor whether the bathroom call light had been fixed, R142 stated, "I don't know, I don't use it." When the surveyor pulled the string on the bathroom call light and the red light began to blink; this was confirmed by R142. When the marquee outside of R142's room was checked; it did not register that the call light had been activated. LPN-C confirmed R142's call light was not registering on the marquee nor was it alerting nursing staff via their radio's. LPN-C then retrieved R142's call light and gave it to environmental services staff (ESS)-A to repair. When interviewed on 11/4/15, at 8:35 a.m. ESS-A stated the call light system had been a problem since it was installed and further stated maintenance was currently working on it. ESS-A stated the nursing assistants were supposed to be checking to make sure the call lights were functioning properly and when problems were identified they were to notify maintenance. ESS-A confirmed that maintenance staff did not perform routine audits on the call light system but stated there had been talk this week of implementing monthly audits. When interviewed on 11/05/15, at 10:52 a.m. the environmental services director (ESD) and volunteer coordinator (VC) verified the facility did not have a formal auditing system to assure call light waer functioning properly. ESD stated when a call light wasn't working the staff were instructed to put it in a designated box for the maintenance staff to repair. ESD confirmed this was their only process. ESD further confirmed this was their only process. ESD further confirmed this was their only process. ESD further confirmed this	On 11/4/15, a seated in recl When question bathroom call don't know, I would the strip the red light be R142. When room was chelight had been R142's call light marquee nor radio's. LPN-and gave it to (ESS)-A to release When interviews tated the call since it was in maintenance stated the number checking the functioning properties of the properties of t	at 8:30 a.m. R142 was observed ecliner in room watching television. tioned by the surveyor whether the all light had been fixed, R142 stated, "I I don't use it." When the surveyor tring on the bathroom call light and the began to blink; this was confirmed by the marquee outside of R142's checked; it did not register that the call then activated. LPN-C confirmed light was not registering on the or was it alerting nursing staff via their N-C then retrieved R142's call light to environmental services staff repair. Wiewed on 11/4/15, at 8:35 a.m. ESS-A call light system had been a problem installed and further stated be was currently working on it. ESS-A call light system had been a problem of the call lights were properly and when problems were ey were to notify maintenance. Firmed that maintenance staff did not untine audits on the call light system but the had been talk this week of the monthly audits. Wiewed on 11/05/15, at 10:52 a.m. the object of the facility did formal auditing system to assure call functioning properly. ESD stated light wasn't working the staff were on put it in a designated box for the set staff to repair. ESD confirmed this only process. ESD further confirmed	23010		

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00138 B. WING 11/05/2015	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		
11/00/2010	00138		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
ST JOHNS LUTHERAN HOME 901 LUTHER PLACE	CLIOHNS LUTHERAN HOME		
ALBERT LEA, MN 56007	JOHNS EUTHERAN HOME		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)	REFIX (EACH DEFICIENC)		
identified 4 other resident call lights that were non-functional. ESD stated a staff from Advanced Wireless Communications (company that installed/services the call light system) came to the facility on 11/4/15 to provide further education related to (r/t) the call light system. ESD stated there was a report that could be printed daily that would identify call light issues such as a low battery (indicated on report as: low battery warning), also issues such as a call not registering on the marquee but registers on the radio or vice/versa, a faulty cord or if the unit had pulled away from the wall (indicated on report as: check-in failure). ESD stated being unaware this report existed and would now be reviewing the report daily to identify potential call light issues. VC verified that if a call light was activated and the red light on the unit was blinking but if did not register on the marquee or the radio it would not show up on the report. VC stated they had discussed putting a plan into place to audit neighborhood each week of the month to check call lights manually. ESD and VC verified call light audits were not being performed by maintenance or nursing staff. When interviewed on 11/05/15, at 12:35 p.m. the ESD stated the nurse managers received a daily email from Advanced Wireless Communications r/t call light response times for the previous day; ESD further stated not having access to this report. ESD stated this report also indicated if there would be a low battery on a call light and the nurse managers would forward this information to maintenance to address. ESD stated being unsure if the email indicated other potential call light issues other than a low battery. When interviewed on 11/05/15, at 1:26 p.m. clinical manager (CM)-C stated when a call light	identified 4 other renon-functional. ES Advanced Wireless that installed/service to the facility on 11/education related to ESD stated there we printed daily that we such as a low batter battery warning), all registering on the mandio or vice/versa, pulled away from the check-in failure). Ereport existed and report daily to ident VC verified that if a the red light on the register on the mandiscussed putting an eighborhood each call lights manually audits were not bein or nursing staff. When interviewed ESD stated the nuremail from Advance report. ESD stated the nuremail from ESD stated the rewould be a lothe nurse manager information to main stated being unsure potential call light is When interviewed to the nurse manager information to main stated being unsure potential call light is When interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated being unsure potential call light is when interviewed to the nurse manager information to main stated the nurse manager information to main stated being unsure potential call light is when interviewed the nurse manager information to main stated being unsure potential call light is when interviewed the nurse manager information to main stated being unsure potential call light is when interviewed the nurse manager information to main stated being unsure potential ca		

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		7. Bolesina.				
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHI	NS LUTHERAN HOME	•	ER PLACE LEA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
23010	isn't functioning produplicate work order maintenance will pinch-C further stated the old call light system affected resident as functional. CM-C communications expended indicating call light previous day. CM-from the previous day. CM-from the previous day. The report included times and the endomaintenance issue not address the mass it was her under received the same confirmed that nurs on residents call light functioning properly. When interviewed c CM-B verified shert from Advanced Wirlight response time CM-B displayed the for surveyor to reviet the maintenance set on CM-C 's activity light audits were not on a regular basis. When she worked uperiodically check the experienced a resident control of the control of	operly it is to be removed, a er is to be filled out, and ck up at the nurses station. It when a call light is removed stem is implemented for the stem is implemented for the stem is implemented for the stem is implemented Wireless mailed daily activity reports response times from the C pulled up the activity report day for the surveyor to view. If the the call light response of the report also included any second to the report also included any second internance section of the report standing that maintenance daily report. CM-C further sing was not conducting audits that to assure they were	23010			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00138	B. WING		11/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST JOH	NS LUTHERAN HOME		ER PLACE .EA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
23010	and put in a box dorbroken call lights arbeing repaired the complemented for the When interviewed communications do call light response to on their email list. SUGGESTED MET The administrator or review, and/or revisensure resident call working order and for designee could edut the policies and prodesignee could devensure ongoing complements.	will deactivate the call light wnstairs in the bin where the e to be placed. If a call light is old system will be affected resident. In 11/5/15, at approximately ted the ESD had been anced Wireless aily activity report related to imes to her as she was not yet. HOD OF CORRECTION: r designee could develop, e policies and procedures to lights were kept in proper unction. The administrator or cate all appropriate staff on cedures. The administrator or elop monitoring systems to	23010			

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