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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5AKR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**
2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

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 S5338026

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245338	A. Building B. Wing	12/17/2015

Name 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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/13/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/13/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/13/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/11/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/08/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **12/03/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/11/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	12/29/2015	03048	12/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/5/2015			

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245338	A. Building B. Wing 01 - MAIN BUILDING 01	12/17/2015

Name 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. # NFPA 101 LSC K0062	Correction Completed 12/07/2015	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 11/30/2015	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 11/30/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	12/29/2015	25822	12/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/3/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5AKR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**
2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 12/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

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

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

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

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.

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	245338	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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F 000	Continued From page 1	F 000		
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		12/13/15

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F 279	Continued From page 2 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure a plan of care was developed for use of blood thinning medication for 1 of 5 (R171) residents reviewed for unnecessary medications. Findings include: Review of the facility Client Diagnosis Report identified R171's admitting diagnosis (11/4/14) included a history of falls, chronic kidney disease stage 3 and vitamin B12 deficiency anemia. Also identified was a diagnosis dated 4/8/15 for deep vein thrombosis (DVT) LE (lower extremity).	F 279	F279 R171 Comprehensive Care Plan was revised on 11/04/15 to include blood thinning medications. All comprehensive care plans for residents receiving blood thinning medications have been reviewed and revised if needed. Nurse Managers were educated on including blood thinning medications on the Comprehensive Care Plans. The Nursing Newsletter date 11/20/15 also included education on including blood thinning medications on the Care Plan.	

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F 279	Continued From page 3 R171's annual Minimum Data Set (MDS) dated 10/7/15 indicated a Brief Interview for Mental Status score of 4 indicative of severe cognitive impairment. The MDS further identified R171 required extensive assist of one person to perform activities of daily living and had 2 or more falls since prior assessment. R171's physician orders for 10/7/15 through 10/31/15 included Coumadin (anticoagulant) 4.5 milligrams (mg) daily at bedtime for DVT. Hold if not eating 2 meals/day. A physician progress note dated 8/14/15 identified R171 had a history of unprovoked DVT for which she receives Coumadin. The physician stated, "Given the fact this was unprovoked, Coumadin was recommended for life unless the risks of bleeding outweigh the benefits." R171's care plan dated 10/20/15, included at risk for falls with major injury and at risk for alteration in skin integrity (bruising/skin tears) related to propels wheelchair, reaches for grab bars/railings, may bump walls/doors/grab bars/railings, poor coordination/balance, history of falls and cognitive loss. The care plan lacked identification of the associated risk for bleeding related to routine use of a blood thinning medication, emergency procedures in the event bruising or uncontrolled bleeding occurred, and foods and other medications to avoid that would increase the risk of bleeding while on Coumadin therapy. During an interview on 11/4/15, at 2:00 p.m. clinical manager (CM)-B verified the care plan did not identify the use of Coumadin and associated risks. She stated she was new to the residents	F 279	The Director of Nursing will audit Comprehensive Care Plans to ensure blood thinning medications are being care planned appropriately. Audits will be done weekly and reviewed at the next quarterly QA/QI meeting for further recommendations.	

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F 279	Continued From page 4 on the wing and had not had time to review all the plans of care. The Coumadin package insert warns of bleeding risk and can cause major bleeding or hemorrhage. Insert included directions to "instruct patient about prevention measures to minimize risk of bleeding and report signs and symptoms of bleeding." Package insert indicated other drugs, diets and other factors could increase the international normalized ratio (lab test that measures clotting time of blood used to measure Coumadin doses). The insert included, "observe caution with administration of Coumadin to elderly patients in any situation or with any physical condition where added risk of hemorrhage is present." The facility policy Anticoagulant Therapy Policy reviewed 8/2014, identified, "Resident is monitored for any adverse signs of bleeding or bruising and MD/NP (medical doctor/nurse practitioner) to be notified."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the plan of care for reporting bruising for 2 of 3 residents (R148, R139) reviewed for non pressure related skin	F 282	F282 R148 bruising was assessed and documented on 11/04/15. Bruising will be monitored until resolved.	12/13/15

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F 282	Continued From page 5 conditions and for proper wheelchair positioning for 2 of 2 residents (153, 136) reviewed with positioning needs. Findings include: On 11/3/15, at 4:18 p.m. R148 was observed in her room sitting upright in the wheelchair. R148 was noted to have a large circular purple bruise located on her right mid forearm. Above the circular bruise was noted a V shaped lighter yellow/purple bruise. Also noted on R148's left arm biceps area a cluster of 4 smaller circular purple/yellow bruises which were in a semi circular shape. The 4 smaller bruises appeared as if they could be finger marks. R148 stated she didn't know how she got the bruises but indicated no one hurt her. R148 had geri sleeves on both arms. The care plan dated October 2015, identified: (1) an alteration in bathing/grooming/dressing with interventions including: Observe and report skin problems and decline to nurse and (2) at risk for altered skin integrity with interventions including: Monitor for breakdown with cares/bath. The progress note entered by the registered nurse (RN) on the physician orders dated 9/1/15 through 9/30/15, identified: bruises easily but skin intact. The treatment record dated 11/1/5 to 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	F 282	R139 bruising was assessed and documented on 11/17/15. Bruising will be monitored until resolved. Nursing staff were educated on 12/04/15 to report skin concerns to Licensed Nurses and Licensed Nurses were educated to complete documentation. Nurse Managers will do on-going audits to ensure that proper monitoring of skin concerns and proper documentation has occurred, and will forward any concerns to the DON. Results of audits will be reviewed at the next Quarterly QA/QI meeting for further recommendations. R153 O.T. was ordered for resident on 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 12/04/15 for proper chair positioning. Nurse Managers and Licensed Nurses were educated on proper chair positioning. Nurse Managers will do on-going audits for proper chair positioning. Concerns will be forwarded to the DON. Results of audits will be reviewed at the next Quarterly QA/QI meeting for further recommendations.	

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(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 breakdown with cares/bath. Also identified was: (2) alteration in bathing, grooming and dressing with interventions including: Observe and report skin problems.

When interviewed on 11/4/15, at 12:30 p.m. nursing assistant (NA)-D confirmed she had assisted R139 with morning cares and had not

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F 282	Continued From page 7	F 282		

noticed the bruises. NA-D stated staff were expected to report to the nurse when skin conditions/bruising were discovered.

Interview with CM-B on 11/4/15, at 1:49 p.m. verified R139's bruising should have been identified, reported to the nurse and monitored. CM-B verified the care plan had not been implemented as written.

On 11/3/15, at 02:23 p.m. R153 was observed seated in a Rock-n-go wheelchair (w/c) in the 1st floor northeast (NE) solarium; R153 was alone in the room. R153's w/c was observed locked in a semi-reclined position; R153 was observed to hold his legs/feet up and stretched outward. There were no leg/foot supports observed on the w/c. R153 was observed for approximately 15-20 minutes. R153's legs feet were observed to move frequently from a stretched out position, to crossing his ankles, bending his knees, dangling his legs, and trying to place his left leg on the wheel of the w/c. When R153 dropped his legs/feet down, they did not reach/touch the floor.

On 11/04/15, at 9:10 a.m. R153 was assisted to the 1st floor NE solarium by nursing assistant (NA)-B for the breakfast meal. R153 was seated in his Rock-n-go w/c in an upright position, the balls of his feet were observed to touch the floor. There were no foot nor leg rests observed on the w/c. NA-B assisted R153 with eating while his w/c remained in the upright position. At 9:56 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

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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 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 and cognitive impairment. Intervention dated 4/30/15 included: "Uses w/c or Rock N Go for LOCOMOTION on/off the unit with assist of 1. Monitor correct positioning. Report changes"

On 11/05/15, at 4:50 p.m. R136 was observed in

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F 282	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.	F 282		
F 309 SS=D	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 by: Based on observation, interview, and document	F 309	F309	12/13/15

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F 309	Continued From page 10 review the facility failed to identify and monitor bruising for 2 of 3 (R148, R139) residents reviewed for non pressure related skin conditions, and failed to provide proper wheelchair and foot support positioning for 2 of 2 residents (R153, R136) reviewed with positioning needs. Findings include: On 11/3/15, at 4:18 p.m. R148 was observed in her room sitting upright in the wheelchair. R148 was noted to have a large circular purple bruise located on her right mid forearm. Above the circular bruise was noted a V shaped lighter yellow/purple bruise. Also noted on R148's left arm biceps area a cluster of 4 smaller circular purple/yellow bruises which were in a semi circular shape. The 4 smaller bruises appeared as if they could be finger marks. R148 stated she didn't know how she got the bruises but indicated no one hurt her. R148 had geri sleeves on both arms. Review of the 9/29/15, annual Minimum Data Set (MDS) indicated a Brief Interview for Mental Status score of 5 which is indicative of severe cognitive impairment and extensive assistance needed with activities of daily living (ADL's). The progress note entered by the registered nurse (RN) on the physician orders dated 9/1/15 through 9/30/15, identified bruises easily but skin intact. The treatment record for 11/1/5 to 11/30/15 indicated, Skin was to be checked on bath day and bruise, rash, open area etc. was to be documented. The treatment record also identified R148 had her bath on 11/2/15. The care plan dated October 2015, identified: (1)	F 309	R148 bruising was assessed and documented on 11/04/15. Bruising will be monitored until resolved. R139 bruising was assessed and documented on 11/17/15. Bruising will be monitored until resolved. Nursing staff were educated on 12/04/15 to report skin concerns to Licensed Nurses and Licensed Nurses were educated to complete documentation. Nurse Managers will do on-going audits to ensure that proper monitoring of skin concerns and proper documentation has occurred, and will forward any concerns to the DON. Results of audits will be reviewed at the next Quarterly QA/QI meeting for further recommendations. R153 O.T. was ordered for resident on 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 12/04/15 for proper chair positioning. Nurse Managers and Licensed Nurses were educated on proper chair positioning. Nurse Managers will do on-going audits for proper chair positioning. Concerns will be forwarded to the DON. Results of audits will be reviewed at the next Quarterly QA/QI meeting for further recommendations.	

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an alteration in bathing/grooming/dressing with interventions including: Observe and report skin problems and decline to nurse and (2) at risk for altered skin integrity with interventions including: Monitor for breakdown with cares/bath.

The identified bruised areas were noted during interview on 11/4/15, at 1:49 p.m. with clinical manager (CM)-B. She stated the bruises to the top of R148 left arm looked like finger marks. She asked R148 whether anyone was rough and R148 stated "no". CM-B verified the bruises had not been reported and should have been identified, reported to the nurse and monitored.

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 11/03/2015, 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."

The quarterly MDS dated 9/2/15, identified a BIMS score of moderately impaired cognition, unable to complete and extensive assistance needed with ADL's. Review of the treatment record for 11/1/15 to 11/30/15, identified skin checked on bath day and document on any bruise, rash, open area etc. R139 had falls on

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F 309	Continued From page 12 10/9/15, 10/15/15, 10/22/15 and 10/29/15. 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. When interviewed on 11/4/15, at 12:30 p.m. nursing assistant (NA)-D confirmed she had assisted R139 with morning cares and had not noticed the bruises. NA-D stated staff were expected to report to the nurse when skin conditions/bruising were discovered. Interview with CM-B on 11/4/15, at 1:49 p.m. verified the bruising should have been identified, reported to the nurse and monitored. On 11/03/15, at 02:23 p.m. R153 was observed seated in a Rock-n-go wheelchair (w/c) in the 1st floor northeast (NE) solarium; R153 was alone in the room. R153's w/c was observed locked in a semi-reclined position; R153 was observed to hold his legs/feet up and stretched outward; there were no leg/foot supports observed on the w/c. R153 was observed for approximately 15-20 minutes. R153's legs feet were observed to move frequently from a stretched out position, to crossing his ankles, bending his knees, dangling his legs, and trying to place his left leg on the wheel of the w/c. When R153 extended his legs/feet downward, they did not touch the floor. On 11/04/15, at 9:10 a.m. R153 was assisted to the 1st floor NE solarium by nursing assistant	F 309		

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(NA)-B for the breakfast meal. R153 was seated in his Rock-n-go w/c in an upright position, the balls of his feet were observed to touch the floor. There were no foot nor leg rests observed on the w/c. NA-B assisted R153 with eating while his w/c remained in the upright position. At 9:56 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 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.

R153's care plan dated 9/22/15 included a 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."

Review of R153's medical record did not include

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F 309	Continued From page 14 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 department 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 decrease the risk for falls. 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, 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. CM-B verified R153's chair was in need of a leg/footrest and further confirmed it would not be good for the resident to be positioned in a reclined position without one. When interviewed on 11/05/15, at 4:21 p.m. the director of nursing (DON) stated being unaware if OT had evaluated R153 r/t wheelchair positioning and further stated it was individualized as to when they would request this. The DON could not confirm or deny whether the resident's w/c positioning when reclined was appropriate without leg/footrests as this was individualized with each resident. R136's quarterly MDS dated 10/2/15 indicated total dependence with transfers and locomotion on unit, and extensive assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. The MDS further indicated short and long term memory problems and severe impairment related to (r/t) daily decision making.	F 309		

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F 309	Continued From page 15 R136's care plan dated 10/16/15 included a problem of impaired physical mobility r/t physical and cognitive impairment. Intervention dated 4/30/15 included: "Uses w/c or Rock N Go for LOCOMOTION on/off the unit with assist of 1. Monitor correct positioning. Report changes" On 11/05/15, at 4:50 p.m. R136 was observed in 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 up. 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 adjusted down the resident's feet could still not touch the footrests when reclined. CM-B confirmed the improper positioning for R136 and stated she would notify OT for further evaluation. 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.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		12/11/15

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F 371	Continued From page 16 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain equipment (can opener) utilized in food preparation in a clean and sanitary condition. This had the potential to affect all 134 residents residing in the facility who consumed foods served from the kitchen. Findings include: The initial kitchen tour was conducted on 11/2/15, at 11:45 am. with the facility dietician (RD) and food service manager (DM). During the initial tour the following sanitary concern was noted: The electric can opener utilized in various food preparation processes was located on the food service counter. A thick buildup of a black oily substance was evident in the area located under and on the back side of the cutting blade. This thick, black oily substance was dripping down the front surface of the can opener. In addition, a heavily soiled black substance was evident on and around the cutting blade of the manual can opener located on the same counter. During the tour on 11/2/15, at 11:45 a.m. the above findings were verified by the RD and DM. When the kitchen cleaning schedule document was reviewed, it was noted a schedule for cleaning the can openers was lacking.	F 371	F371 All can openers were taken apart and thoroughly cleaned on 11/2/2015 by the Dietary Manager. The cleaning of can openers has been added to the dietary cleaning schedule. On 12/1/15 an in-service for the dietary staff was held by the Registered Dietician and Dietary Manager to address sanitation and the updated cleaning schedule. Weekly audits of the cleanliness of the kitchen will be conducted by the Registered Dietician and/or Dietary Manager for two months to ensure compliance. After the two month period, monthly audits will continue to occur. The first audit is scheduled to be conducted on 12/11/15. The audits and cleaning schedules will continue to be monitored by the Registered Dietician and discussed at Quality Assurance meetings.	

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		12/8/15

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F 441	Continued From page 18 This 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. Findings include: It was was observed on 11/3/15, at 5:42 p.m. that personal protective equipment (PPE) including gloves and gowns was stored in a three drawer Rubbermaid container located outside the door of R92's room. There was no magnet located on the door of this room to alert staff of special precautions nor was there any information located in the three drawer container related to any special contact precautions. When interviewed on 11/3/15, at 5:45 p.m. nursing community assistant (NCA)-A stated last week R92 was contagious with something but didn't know with what; however, indicated a staff gown was required when R92 was assisted to the bathroom. NCA-A added since there remained PPE outside the door, R92 must still be contagious. On 11/3/15, at 5:53 p.m. clinical manager (CM)-A stated R92 had Clostridium difficile (C-diff) and they couldn't post signs alerting staff and visitors of the problem with R92, so staff communicate this information to the oncoming staff during report. CM-A stated they instruct oncoming staff to wear gloves, gowns, perform handwashing and instruct R92 to wash his hands prior to leaving the room. CM-A also indicated they try to catch family and/or visitors to inform them about any	F 441	F-441 Resident 92 had sign placed on room door indicating to check with nurse before entering on 11/6/15. Re-education of R92's nurses and CNA's was put in their communication book on 11/6/15. This communication alerted staff to the isolation precautions needed for R92. All nursing staff (licensed and certified) are being re-educated and updated on the newly developed C. Diff. Precautions Kit at all reports for all shifts for 5 days dated December 3 through December 8, 2015. Staff are educated as to where to find the new C. Diff Precaution Kit. The Precaution Kit includes detailed instructions to ensure compliance with infection control standard of practices, and St. John□s Infection Control Policy. The kit has a" check with the nurse" sign, a cheat sheet for everything that needs to be done to implement the precautions, a specific notification sheet to be placed in the communication book, an educational handout for resident/family, and educational handout on contact precautions for staff. The RN Infection Control Nurse will audit for contact precaution compliance. This education will also be reviewed during orientation with newly hired licensed staff.	

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F 441	Continued From page 19 special contact precautions. 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. During an interview on 11/5/15, at 10:30 a.m. registered nurse (RN)-A stated that when a resident requires special contact precautions staff is alerted by placing a magnet on the resident's door. RN-A stated she also places printed information in the drawer of the Rubbermaid container which explains to staff the type of contact precautions required. RN-A also stated the NA's communication book should include documentation/notification related to residents who require special contact precautions. RN-A explained that nursing staff should review the communication book every time they work. When later interviewed on 11/5/15, at 12:04 p.m. RN-A verified there was no magnet on R92's door identifying that special contact precautions were required nor was there printed information available in the Rubbermaid container. RN-A also agreed that family and/or visitors were not alerted to any special contact precautions nor was system evident which alerted them to check with nursing staff prior to their visit and/or entering the room. 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	F 441		

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F 441	Continued From page 20 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. The policy Isolation and Transmission Based Precautions, reviewed 9/08, identified the purpose as: To reduce the risk of infectious disease transmission between residents and to protect personnel and visitors from exposure to recognized sources of infection. The policy also identified the following: *Transmission Based Precautions will be instituted, in addition to Standard Precautions, for residents known or suspected to be infected or colonized with specific microorganisms spread by airborne, droplet, or contact routes of transmission. Identified Resident Management as: *Visitors will be instructed in the practice of Standard Precautions. When isolation precautions are in place, visitors are expected to wash hands upon entering and leaving isolation room.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that 5 of 40 resident (R33, R75, R106, R139, R142) call lights activated were functioning properly so that	F 463	F463 The call light in room 116 was repaired, tested, and then returned to the room on 11/3/15 by maintenance staff. The	12/3/15

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F 463	Continued From page 21 residents had a means of contacting staff. Findings include: During an observation on 11/3/15, at 12:28 p.m. R139's bedroom (room 116) was observed without a call light; the bathroom call light did not function. When interviewed on 11/3/15, at 12:29 p.m. licensed practical nurse (LPN)-B confirmed R139's bathroom call light was not functioning. LPN-B further stated the bedroom call light had stopped functioning that morning and had been given to maintenance for repair. During an observation on 11/3/15, at 12:35 p.m. R142's (room 172) bathroom call light was activated. Upon pulling the cord, the red light on the call light unit started to blink. However, the call light did not register on the marquee outside of the resident's room near the 1 South nurse's station, indicating the call light had been activated. Surveyor alerted LPN-C who verified the call light was not registering on the marquee. LPN-C further verified the call light was not alerting the nursing staff on their radio's that the call light had been activated. The call light system routinely alerts nursing staff on their radios when resident call lights are activated. LPN-C gave R142's bathroom call light to a passing nursing assistant (NA) and asked that she bring it to maintenance for repair. 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. During an observation on 11/3/15, at 1:13 p.m. R33's (room 124) bedroom and bathroom call	F 463	bathroom call light battery in room 116 was replaced, the call light was tested to assure that it was operating correctly, and then returned to the room by maintenance staff on 11/3/15. The call light battery in room 172 was replaced, tested by maintenance staff to assure that it was operating correctly, and then returned to the room on 11/3/15. The call light batteries in the bedroom and bathroom of room 109 were replaced, tested to assure that it was operating correctly, and then returned to the room on 11/3/15. The call light cord in room 124 was replaced by a new pressure sensitive cord by maintenance staff on 11/3/15. The battery was also tested to assure that the call light was operating properly. The bathroom call light transmitter was reprogrammed, the batteries were replaced, the transmitter was tested to assure correct operation, and then returned to the room by maintenance on 11/3/15. The call box jack in room 136 was replaced, tested to assure proper operation, and then returned to the room 136 by maintenance on 11/3/15. Access to a daily maintenance report that identifies current and potential problems with each call light was established for the EVS Director on 11/4/15. This report helps to isolate maintenance issues and identify which call lights need attention. Advanced Wireless technicians were contacted on 11/4/15 and came to the facility on 11/6/15 to assess and assure that all devices related to the call light	

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F 463	Continued From page 22 lights were tested and neither functioned. Nursing assistant (NA)-C was alerted and verified the call lights were not functioning. NA-C continued to test the call lights and after several attempts both call lights eventually functioned and activated the call light system. During an observation on 11/3/15, at 1:51 p.m. R75's (room 136) bedroom call light was tested and did not function. R75 indicated to the surveyor that sometimes the call light cord becomes loose and needs to be pushed back up into the call light box unit. Subsequently, when the surveyor pushed the cord into the box unit, the call light functioned properly. On 11/4/15, at 8:30 a.m. R142 was observed seated in recliner 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	F 463	system were operational. On 11/17/15 the EVS Director and Volunteer Coordinator developed a written Call Light Repair Form for staff to use in the event that they notice a call light malfunction. The form includes a troubleshooting checklist, and a carbon copy of the form is created when the form is filled out. In addition to the Call Light Repair Form a Repair Log was created on 11/7/15 to detail and record individual call light repairs and replacements. The Administrator, EVS Director, and Volunteer Coordinator held a conference call with the lead technician at Advanced Wireless on 12/1/15 to discuss further improvements to the system. Advance Wireless programing support staff were also on this conference call. The lead technician at Advanced Wireless is scheduled to come to the facility on 12/3/15 to further refine the functionality of the call light system. Audits of randomized call lights will be conducted monthly and rotate through each wing of the building. The corrective action regarding F463 was completed on 11/7/15. The EVS Director will continue to monitor (1) Daily Call Light Maintenance Reports sent by Advance Wireless, (2) the Call Light Repair Forms, and (3) the Repair Log. This will be a daily and ongoing responsibility of the EVS Directors. In the event that the EVS Director is out of the building, the lead maintenance man will be trained to check, monitor and repair the call light system.	

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F 463	Continued From page 23	F 463		

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 lights were 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 that on 11/3/15 after surveyors identified the above call light issues - maintenance staff 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 (indicted 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 it 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 1

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	245338	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 24	F 463		

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 isn't functioning properly it is to be removed, a duplicate work order is to be filled out, and maintenance will pick up at the nurses station. CM-C further stated when a call light is removed the old call light system is implemented for the affected resident as the previous system is still functional. CM-C confirmed Advanced Wireless Communications emailed daily activity reports indicating call light response times from the previous day. CM-C pulled up the activity report from the previous day for the surveyor to view. The report included the the call light response times and the end of the report also included any maintenance issues. CM-C confirmed she did not address the maintenance section of the report as it was her understanding that maintenance received the same daily report. CM-C further confirmed that nursing was not conducting audits on residents call lights to assure they were

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F 463	Continued From page 25 functioning properly. When interviewed on 11/05/15, at 1:47 p.m. CM-B verified she received a daily activity report from Advanced Wireless Communications r/t call light response times from the previous day. CM-B displayed the daily report on her computer for surveyor to review; the report did not include the maintenance section as previously visualized on CM-C 's activity report. CM-B confirmed call light audits were not being performed by nursing on a regular basis. CM-B further stated that when she worked upstairs as a floor nurse would periodically check the call lights as had experienced a resident who had to yell out to staff for help because her call light battery was dead. CM-B stated after that she would do periodic call light checks but had not implemented this practice since moving to her new position on the first floor. CM-B stated when a faulty call light is identified staff are to notify maintenance if still in the building - if not will deactivate the call light and put in a box downstairs in the bin where the broken call lights are to be placed. If a call light is being repaired the old system will be implemented for the affected resident. When interviewed on 11/5/15, at approximately 2:30 p.m. CM-A stated the ESD had been forwarding the Advanced Wireless Communications daily activity report related to call light response times to her as she was not yet on their email list.	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		12/11/15

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F 465	Continued From page 26 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the dietary kitchen. This practice had the potential to affect all 134 residents who received food from the kitchen. Findings include: The initial kitchen tour was conducted on 11/2/15, at 11:45 am. with the facility dietician (RD) and food service manager (DM). During the initial tour the following sanitary concerns were noted: 1. The upright storage freezer in the kitchen was identified to have excessive food and debris buildup (heavily soiled) 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. 2. The fire suppression feed lines under the cook stove hood were noted to have a heavy buildup of grease and dust. The feed lines were coated with dust which was hanging from the lines. At the time of the observation, staff were cooking three large pots of Bratwurst directly under these heavily soiled feed lines. 3. The wall on the left side of the cook stove adjacent to the cook stove hood was also noted to have a heavy build up of dust and a coating of	F 465	F465 1. On 11/2/15 the upright storage freezer was cleaned and excessive food was removed from the bottom of the freezer by the Dietary Manager. Cleaning the upright storage freezer was added to the regular cleaning schedule. On 12/1/15 sanitary practices and the re-developed cleaning schedule was reviewed with dietary staff. 2. On 11/2/15 the fire suppression feed lines under the cook stove hood were cleaned by the dietary staff. Cleaning the fire suppression feed lines under the cook stove hood has been added to the maintenance regular cleaning schedule. On 12/1/15 sanitary practices and the re-developed cleaning schedule was reviewed with dietary staff. 3. On 11/2/15 the wall on the left side of the cook stove adjacent to the cook stove hood was cleaned by dietary staff. Cleaning the walls near the cook stove hood has been added to the regular 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 from the floor of the large walk-in storage freezer in the basement by the dietary manager. The floor is scheduled to be cleaned by maintenance on 12/4/15. Cleaning the floor has been added to the	

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	245338	A. BUILDING _____ B. WING _____	11/05/2015

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F 465	Continued From page 27 grease. The fire suppression system feed lines on the wall running vertical were also noted to be heavily soiled. 4. The large walk-in storage freezer in the basement was noted to have boxes of chicken drummies stored directly on the floor. The DM identified the boxes had been delivered on the previous Friday and had been left on the dirty appearing floor since delivery. It was noted the available shelving in the freezer was already filled with supplies. The DM verified the dietary expectation/standard was to store items on shelves and not on the floor in the walk-in freezer. During the tour on 11/2/15, at 11:45 a.m. all of the above findings were verified by the RD and DM. The DM stated the hood over the cook stove was routinely cleaned on a schedule but the feed lines to the fire suppression system were not identified as part of routine cleaning. Review of the kitchen cleaning list failed to identify cleaning the inside of the upright freezer. The cleaning list identified that the back wall adjacent to the cook stove hood was to be cleaned on a daily basis.	F 465	regular maintenance cleaning schedule. On 12/1/15 sanitary practices and the re-developed cleaning schedule was reviewed with dietary staff. Weekly audits of the cleanliness of the kitchen will be conducted by the registered dietician and/or dietary manager for two months to ensure compliance. After the two month period, monthly audits will continue to occur. The first audit is scheduled to be conducted on 12/11/15. The audits and cleaning schedules will continue to be monitored by the Registered Dietician and discussed at Quality Assurance meetings.	

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	245338	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/03/2015**

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ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE** **ALBERT LEA, MN 56007**

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

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

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.

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

St. Johns Lutheran Home building was constructed at 4 different times. The original building is a 3 story building and was constructed in 1960. It was determined to be of Type II(222) construction. In 1964, a 2 story addition was added to the northeast and southeast wings that was determined to be of Type II(222) construction. In 1967, a 2 story addition was constructed to the North and South that was determined to be of Type II(222) construction. In 1980, a 2 story addition was added to the South Annex and was determined to be Type II (111). Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as a Type

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K 000	Continued From page 2 II(111) building. The facility is fully sprinkled . The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 170 beds and had a census of 134 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the fire sprinkler system in accordance with NFPA 101 Life Safety Code (2000 edition), Chapter 19, Section 19.7.6 and Chapter 4, Section 4.6.12 and NFPA 25 (1998 edition). In a fire emergency, this deficient practice could adversely affect 8 of 8 patients, staff and visitors. FINDINGS INCLUDE: On 11/03/2015 between 8:00 AM and 11:00 AM, during a review of available records, it was	K 062	K062 Olympic Fire was contacted to conduct the annual sprinkler flow test. The flow test will be completed on December 7, 2015. Olympic Fire will also instruct St. John□s maintenance staff on how to conduct quarterly flow tests. The flow test will be completed once per year by Olympic Fire, and quarterly by St. John□s maintenance staff. The Environmental Services Director will keep a record of, and monitor these tests	12/7/15

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ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE** **ALBERT LEA, MN 56007**

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K 062	Continued From page 3 confirmed that required quarterly flow tests of the fire sprinkler system had not been conducted during the previous year. Quarterly flow tests are designed to test water flow alarm devices, pressure switches, water motor gongs and other required devices of a fire sprinkler system. This deficient practice was not in conformance with NFPA 25 (1998 edition) Chapter 2, Section 2-3 and Chapter 9, Section 9-2. This finding was confirmed with the Building Engineer (PM).	K 062	in order to assure compliance.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 08:00 AM and 11:00 AM on 11/03/2015, observation and documentation	K 154	K154 A policy and procedure specific to the Automatic Sprinkler System was written on 11/30/15 that addresses St. John□s Plan of Action in the event that the Automatic Sprinkler System is out of service for more than 4 hours in a 24-hour period. The procedure includes notification to the State Fire Marshal Office and the local Fire Department.	11/30/15

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K 154	Continued From page 4 reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (PM) at the time of discovery.	K 154	The plan is located in the Environmental Services Director□s office and in the Emergency Manuals that are located at each of the nurse□s stations. The Administrator will monitor for ongoing compliance, and will make changes to the Policy or Procedure when recommended by the State Fire Marshal Office.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 08:00 AM and 11:00 AM on 11/03/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the	K 155	K155 The policy and procedure was updated on 11/30/15 that addresses St. John□s Plan of Action in the event that the Fire Alarm System is out of service for more than 4 hours in a 24-hour period. The procedure includes notification to the State Fire Marshal Office and the local Fire Department. The plan is located in the Environmental Services Director□s office and in the Emergency Manuals that are located at each of the nurse□s stations. The Administrator will monitor for ongoing compliance, and will make changes to the Policy or Procedure when recommended	11/30/15

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K 155	Continued From page 5 Facility Maintenance Director (PM) at the time of discovery.	K 155	by the State Fire Marshal Office.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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	00138	A. BUILDING: _____ B. WING _____	11/05/2015

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ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: _____ B. WING _____	11/05/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 2nd, 3rd, 4th and 5th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which 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.	

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview the facility failed to ensure a plan of care was developed for use of blood thinning medication for 1 of 5 (R171) residents reviewed for unnecessary medications. Findings include: Review of the facility Client Diagnosis Report identified R171's admitting diagnosis (11/4/14) included a history of falls, chronic kidney disease stage 3 and vitamin B12 deficiency anemia. Also identified was a diagnosis dated 4/8/15 for deep vein thrombosis (DVT) LE (lower extremity). R171's annual Minimum Data Set (MDS) dated 10/7/15 indicated a Brief Interview for Mental	2 560	Corrected	12/13/15

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2 560	Continued From page 3 Status score of 4 indicative of severe cognitive impairment. The MDS further identified R171 required extensive assist of one person to perform activities of daily living and had 2 or more falls since prior assessment. R171's physician orders for 10/7/15 through 10/31/15 included Coumadin (anticoagulant) 4.5 milligrams (mg) daily at bedtime for DVT. Hold if not eating 2 meals/day. A physician progress note dated 8/14/15 identified R171 had a history of unprovoked DVT for which she receives Coumadin. The physician stated, "Given the fact this was unprovoked, Coumadin was recommended for life unless the risks of bleeding outweigh the benefits." R171's care plan dated 10/20/15, included at risk for falls with major injury and at risk for alteration in skin integrity (bruising/skin tears) related to propels wheelchair, reaches for grab bars/railings, may bump walls/doors/grab bars/railings, poor coordination/balance, history of falls and cognitive loss. The care plan lacked identification of the associated risk for bleeding related to routine use of a blood thinning medication, emergency procedures in the event bruising or uncontrolled bleeding occurred, and foods and other medications to avoid that would increase the risk of bleeding while on Coumadin therapy. During an interview on 11/4/15, at 2:00 p.m. clinical manager (CM)-B verified the care plan did not identify the use of Coumadin and associated risks. She stated she was new on the wing and hadn't gotten a chance to review all the plans of care. The Coumadin package insert warns of bleeding	2 560		

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2 560	Continued From page 4 risk and can cause major bleeding or hemorrhage. Insert included directions to "instruct patient about prevention measures to minimize risk of bleeding and report signs and symptoms of bleeding." Package insert indicated other drugs, diets and other factors could increase the international normalized ratio (lab test that measures clotting time of blood used to measure Coumadin doses). The insert included, "observe caution with administration of Coumadin to elderly patients in any situation or with any physical condition where added risk of hemorrhage is present." The facility policy Anticoagulant Therapy Policy reviewed 8/2014, identified, "Resident is monitored for any adverse signs of bleeding or bruising and MD/NP (medical doctor/nurse practitioner) to be notified." SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to the development of care plans. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		12/13/15

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2 565	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow the plan of care for reporting bruising for 2 of 3 residents (R148, R139) reviewed for non pressure related skin conditions and for proper wheelchair positioning for 2 of 2 residents (153, 136) reviewed with positioning needs. Findings include: On 11/3/15, at 4:18 p.m. R148 was observed in her room sitting upright in the wheelchair. R148 was noted to have a large circular purple bruise located on her right mid forearm. Above the circular bruise was noted a V shaped lighter yellow/purple bruise. Also noted on R148's left arm biceps area a cluster of 4 smaller circular purple/yellow bruises which were in a semi circular shape. The 4 smaller bruises appeared as if they could be finger marks. R148 stated she didn't know how she got the bruises but indicated no one hurt her. R148 had geri sleeves on both arms. The care plan dated October 2015, identified: (1) an alteration in bathing/grooming/dressing with interventions including: Observe and report skin problems and decline to nurse and (2) at risk for altered skin integrity with interventions including: Monitor for breakdown with cares/bath. The progress note entered by the registered nurse (RN) on the physician orders dated 9/1/15 through 9/30/15, identified: bruises easily but skin intact. The treatment record dated 11/1/5 to	2 565	Corrected	

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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 breakdown with cares/bath. Also identified was:	2 565		

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2 565	Continued From page 7 (2) alteration in bathing, grooming and dressing with interventions including: Observe and report skin problems. When interviewed on 11/4/15, at 12:30 p.m. nursing assistant (NA)-D confirmed she had assisted R139 with morning cares and had not noticed the bruises. NA-D stated staff were expected to report to the nurse when skin conditions/bruising were discovered. Interview with CM-B on 11/4/15, at 1:49 p.m. verified R139's bruising should have been identified, reported to the nurse and monitored. CM-B verified the care plan had not been implemented as written. On 11/3/15, at 02:23 p.m. R153 was observed seated in a Rock-n-go wheelchair (w/c) in the 1st floor northeast (NE) solarium; R153 was alone in the room. R153's w/c was observed locked in a semi-reclined position; R153 was observed to hold his legs/feet up and stretched outward. There were no leg/foot supports observed on the w/c. R153 was observed for approximately 15-20 minutes. R153's legs feet were observed to move frequently from a stretched out position, to crossing his ankles, bending his knees, dangling his legs, and trying to place his left leg on the wheel of the w/c. When R153 dropped his legs/feet down, they did not reach/touch the floor. On 11/04/15, at 9:10 a.m. R153 was assisted to the 1st floor NE solarium by nursing assistant (NA)-B for the breakfast meal. R153 was seated in his Rock-n-go w/c in an upright position, the balls of his feet were observed to touch the floor. There were no foot nor leg rests observed on the w/c. NA-B assisted R153 with eating while his w/c remained in the upright position. At 9:56	2 565		

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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 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 and cognitive impairment. Intervention dated	2 565		

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2 565	Continued From page 9 4/30/15 included: "Uses w/c or Rock N Go for LOCOMOTION on/off the unit with assist of 1. Monitor correct positioning. Report changes" On 11/05/15, at 4:50 p.m. R136 was observed in 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.	2 565		

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2 565	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor bruising for 2 of 3 (R148, R139) residents reviewed for non pressure related skin conditions, and failed to provide proper wheelchair and foot support positioning for 2 of 2 residents (R153, R136) reviewed with positioning needs. Findings include: On 11/3/15, at 4:18 p.m. R148 was observed in her room sitting upright in the wheelchair. R148 was noted to have a large circular purple bruise located on her right mid forearm. Above the circular bruise was noted a V shaped lighter yellow/purple bruise. Also noted on R148's left	2 830	Corrected	12/13/15

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2 830	Continued From page 11 arm biceps area a cluster of 4 smaller circular purple/yellow bruises which were in a semi circular shape. The 4 smaller bruises appeared as if they could be finger marks. R148 stated she didn't know how she got the bruises but indicated no one hurt her. R148 had geri sleeves on both arms. Review of the 9/29/15, annual Minimum Data Set (MDS) indicated a Brief Interview for Mental Status score of 5 which is indicative of severe cognitive impairment and extensive assistance needed with activities of daily living (ADL's). The progress note entered by the registered nurse (RN) on the physician orders dated 9/1/15 through 9/30/15, identified bruises easily but skin intact. The treatment record for 11/1/5 to 11/30/15 indicated, Skin was to be checked on bath day and bruise, rash, open area etc. was to be documented. The treatment record also identified R148 had her bath on 11/2/15. The care plan dated October 2015, identified: (1) an alteration in bathing/grooming/dressing with interventions including: Observe and report skin problems and decline to nurse and (2) at risk for altered skin integrity with interventions including: Monitor for breakdown with cares/bath. The identified bruised areas were noted during interview on 11/4/15, at 1:49 p.m. with clinical manager (CM)-B. She stated the bruises to the top of R148 left arm looked like finger marks. She asked R148 whether anyone was rough and R148 stated "no". CM-B verified the bruises had not been reported and should have been identified, reported to the nurse and monitored. On 11/5/15, at 3:21 p.m. the bruises were	2 830		

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2 830	Continued From page 12 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 11/03/2015, 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." The quarterly MDS dated 9/2/15, identified a BIMS score of moderately impaired cognition, unable to complete and extensive assistance needed with ADL's. Review of the treatment record for 11/1/15 to 11/30/15, identified skin checked on bath day and document on any bruise, rash, open area etc. R139 had falls on 10/9/15, 10/15/15, 10/22/15 and 10/29/15. 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 and decline to nurse. When interviewed on 11/4/15, at 12:30 p.m. nursing assistant (NA)-D confirmed she had assisted R139 with morning cares and had not noticed the bruises. NA-D stated staff were expected to report to the nurse when skin	2 830		

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2 830	Continued From page 13 conditions/bruising were discovered. Interview with CM-B on 11/4/15, at 1:49 p.m. verified the bruising should have been identified, reported to the nurse and monitored. On 11/03/15, at 02:23 p.m. R153 was observed seated in a Rock-n-go wheelchair (w/c) in the 1st floor northeast (NE) solarium; R153 was alone in the room. R153's w/c was observed locked in a semi-reclined position; R153 was observed to hold his legs/feet up and stretched outward; there were no leg/foot supports observed on the w/c. R153 was observed for approximately 15-20 minutes. R153's legs feet were observed to move frequently from a stretched out position, to crossing his ankles, bending his knees, dangling his legs, and trying to place his left leg on the wheel of the w/c. When R153 extended his legs/feet downward, they did not touch the floor. On 11/04/15, at 9:10 a.m. R153 was assisted to the 1st floor NE solarium by nursing assistant (NA)-B for the breakfast meal. R153 was seated in his Rock-n-go w/c in an upright position, the balls of his feet were observed to touch the floor. There were no foot nor leg rests observed on the w/c. NA-B assisted R153 with eating while his w/c remained in the upright position. At 9:56 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	2 830		

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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 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 decrease the risk for falls. 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, 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		

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2 830	Continued From page 15 CM-B verified R153's chair was in need of a leg/footrest and further confirmed it would not be good for the resident to be positioned in a reclined position without one. When interviewed on 11/05/15, at 4:21 p.m. the director of nursing (DON) stated being unaware if OT had evaluated R153 r/t wheelchair positioning and further stated it was individualized as to when they would request this. The DON could not confirm or deny whether the resident's w/c positioning when reclined was appropriate without leg/footrests as this was individualized with each resident. R136's quarterly MDS dated 10/2/15 indicated total dependence with transfers and locomotion on unit, and extensive assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. The MDS further indicated short and long term memory problems and severe impairment related to (r/t) daily decision making. R136's care plan dated 10/16/15 included a problem of impaired physical mobility r/t physical and cognitive impairment. Intervention dated 4/30/15 included: "Uses w/c or Rock N Go for LOCOMOTION on/off the unit with assist of 1. Monitor correct positioning. Report changes" On 11/05/15, at 4:50 p.m. R136 was observed in 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	2 830		

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2 830	Continued From page 16 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 adjusted down the resident's feet could still not touch the footrests when reclined. CM-B confirmed the improper positioning for R136 and stated she would notify OT for further evaluation. 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions and related to monitoring resident wheelchairs/positioning. The Director of Nursing or her designee could educate staff on the policies and procedures. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		12/13/15

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21015	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain equipment (can opener) utilized in food preparation in a clean and sanitary condition. This had the potential to affect all 134 residents residing in the facility who consumed foods served from the kitchen. Findings include: The initial kitchen tour was conducted on 11/2/15, at 11:45 am. with the facility dietician (RD) and food service manager (DM). During the initial tour the following sanitary concern was noted: The electric can opener utilized in various food preparation processes was located on the food service counter. A thick buildup of a black oily substance was evident in the area located under and on the back side of the cutting blade. This thick, black oily substance was dripping down the front surface of the can opener. In addition, a heavily soiled black substance was evident on and around the cutting blade of the manual can opener located on the same counter. During the tour on 11/2/15, at 11:45 a.m. the above findings were verified by the RD and DM. When the kitchen cleaning schedule document was reviewed, it was noted a schedule for cleaning the can openers was lacking. SUGGESTED METHOD OF CORRECTION: The director of dietary services could develop a cleaning schedule for all areas of the kitchen and develop a system to audit compliance with the schedule. The director of dietary services could also provide education to dietary staff on the prevention of food borne illness through good	21015	Corrected	

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21015	Continued From page 18 sanitary practices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program 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. Findings include: It was was observed on 11/3/15, at 5:42 p.m. that personal protective equipment (PPE) including gloves and gowns was stored in a three drawer Rubbermaid container located outside the door of R92's room. There was no magnet located on the door of this room nor was there any information in the three drawer container related to any special contact precautions required of staff. When interviewed on 11/3/15, at 5:45 p.m. nursing community assistant (NCA)-A stated last week R92 was contagious with something but didn't know with what; however, indicated a staff gown was required when R92 was assisted to the	21375	Corrected	12/13/15

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21375	Continued From page 19	21375		

bathroom. NCA-A added since there remained PPE outside the door, R92 must still be contagious.

On 11/3/15, at 5:53 p.m. clinical manager (CM)-A stated R92 had Clostridium difficile (C-diff) and they couldn't post signs alerting staff and visitors what was going on with R92, so staff pass the information during report to the oncoming staff. CM-A stated they instruct oncoming staff to wear gloves, gowns, perform handwashing and instruct R92 to wash his hands prior to leaving the room. CM-A also indicated they try to catch family and/or visitors to inform them about the special contact precautions.

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.

During an interview on 11/5/15, at 10:30 a.m. registered nurse (RN)-A stated that when a resident requires special contact precautions staff is alerted by placing a magnet on the resident's door. RN-A stated she also places printed information in the drawer of the Rubbermaid container which explains to staff the type of contact precautions required. RN-A also stated the NA's communication book should include documentation/notification related to residents who require special contact precautions. RN-A explained that nursing staff should review the communication book every time they work.

When later interviewed on 11/5/15, at 12:04 p.m. RN-A verified there was no magnet on R92's door identifying that special contact precautions were required nor was there printed information

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available in the Rubbermaid container. RN-A also agreed that family and/or visitors were not alerted to any special contact precautions nor was system evident which alerted them to check with nursing staff prior to their visit and/or entering the room.

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.

The policy Isolation and Transmission Based Precautions, reviewed 9/08, identified the purpose as: To reduce the risk of infectious disease transmission between residents and to protect personnel and visitors from exposure to recognized sources of infection. The policy also identified the following: *Transmission Based Precautions will be instituted, in addition to Standard Precautions, for residents known or suspected to be infected or colonized with specific microorganisms spread by airborne, droplet, or contact routes of transmission. Identified Resident Management as: *Visitors will be instructed in the practice of Standard Precautions. When isolation precautions are in place, visitors are expected to wash hands when entering and leaving the isolation room.

SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise infection control policies and

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21375	Continued From page 21 procedures. Nursing staff could be educated as necessary to the importance of hand hygiene and notification of visitors when special precautions are necessary. The DON or designee, could develop an audit tool to ensure policies are implemented per facility policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected	12/13/15

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21426	Continued From page 22	21426		

facility failed to perform a 2-Step tuberculin skin test (TST) per current Center for Disease Control and Prevention (CDC) recommendations and per facility policy for 3 of 5 employees reviewed for Tuberculosis (TB) Prevention and Control.

Findings include:

Dietary aide (DA)-A had a hire date of 8/28/15, and had the tuberculosis screening on 9/1/15, and first TST application on 9/2/15. There was no evidence of a second TST application.

Nursing assistant (NA)-E had a hire date of 9/9/15, and had the tuberculosis screening and first TST application on 9/9/15. There was no evidence of a second TST application.

Housekeeper (HSK)-A had a hire date of 10/13/15, and had the tuberculosis screening and first TST application on 10/13/15. The second TST was given on 10/26/15, however the results were read 96 hours after given on 10/30/15, and instructions were given to repeat the second TST. There was no evidence of the second TST being repeated and read within the 48-72 hour time frame.

During an interview on 11/05/15, at 11:01 a.m. registered nurse (RN)-A confirmed the completion of the two step TST was not completed on three of the employees whose records were reviewed. RN-A stated the staff failed to return as instructed for the second step TST and in addition, the facility failed to appropriately track the completion of the second step.

The facility Standard Guidelines for Facility Tuberculosis Prevention and Control Program dated 5/2015, indicated all health care workers

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21426	Continued From page 23 must receive a two step tuberculin skin test. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate all employees regarding TB education and the facility infection control plan. The director of nursing could monitor compliance for screening and TST for employees and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the dietary kitchen. This practice had the potential to affect all 134 residents who received food from the kitchen. Findings include: The initial kitchen tour was conducted on 11/2/15, at 11:45 am. with the facility dietician (RD) and	21695	Corrected	12/13/15

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21695	Continued From page 24 food service manager (DM). During the initial tour the following sanitary concerns were noted: 1. The upright storage freezer in the kitchen was identified to have excessive food and debris buildup (heavily soiled) 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. 2. The fire suppression feed lines under the cook stove hood were noted to have a heavy buildup of grease and dust. The feed lines were coated with dust which was hanging from the lines. At the time of the observation, staff were cooking three large pots of Bratwurst directly under these heavily soiled feed lines. 3. The wall on the left side of the cook stove adjacent to the cook stove hood was also noted to have a heavy build up of dust and a coating of grease. The fire suppression system feed lines on the wall running vertical were also noted to be heavily soiled. 4. The large walk-in storage freezer in the basement was noted to have boxes of chicken drummies stored directly on the floor. The DM identified the boxes had been delivered on the previous Friday and had been left on the dirty appearing floor since delivery. It was noted the available shelving in the freezer was already filled with supplies. The DM verified the dietary expectation/standard was to store items on shelves and not on the floor in the walk-in freezer. During the tour on 11/2/15, at 11:45 a.m. all of the above findings were verified by the RD and DM. The DM stated the hood over the cook stove was routinely cleaned on a schedule but the feed lines	21695		

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21695	Continued From page 25 to the fire suppression system were not identified as part of routine cleaning. Review of the kitchen cleaning list failed to identify cleaning the inside of the upright freezer. The cleaning list identified that the back wall adjacent to the cook stove hood was to be cleaned on a daily basis. SUGGESTED METHOD OF CORRECTION: The dietary manager could develop a cleaning schedule which included all areas of the kitchen, including the walk-in freezers and the areas around the stove/hood. An audit could be conducted periodically and report to the quality assurance committee at the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family	21942	Corrected	12/13/15

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	00138	A. BUILDING: _____ B. WING _____	11/05/2015

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21942	Continued From page 26 council during the past calendar year. Findings include: During an interview on 11/5/15, at 11:48 p.m. the activity director (AD) stated at the current time a family council was non-existent. AD confirmed the last family council meeting was 3/6/14 and further explained that all the family members who attended in the past had their resident/parent pass away, so a family council no longer existed. AD stated she was planning on having a meeting on 11/17/15 and had her staff submit names of 4 or 5 family members who visit frequently on each unit and planned to invite those people. AD stated she was not planning on sending the information to families of all the residents in the facility. AD verified no attempts to re-establish family council had been made since 3/6/14. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a family council. The DON could monitor to assure that all family members are given the opportunity to attend a family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be	23010		12/13/15

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23010	Continued From page 27 connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that 5 of 40 resident (R33, R75, R106, R139, R142) call lights activated were functioning properly so that residents had a means of contacting staff. Findings include: During an observation on 11/3/15, at 12:28 p.m. R139's bedroom (room 116) was observed without a call light; the bathroom call light did not function. When interviewed on 11/3/15, at 12:29 p.m. licensed practical nurse (LPN)-B confirmed R139's bathroom call light was not functioning. LPN-B further stated the bedroom call light had stopped functioning that morning and had been given to maintenance for repair. During an observation on 11/3/15, at 12:35 p.m.	23010	Corrected	

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23010	Continued From page 28 R142's (room 172) bathroom call light was activated. Upon pulling the cord, the red light on the call light unit started to blink. However, the call light did not register on the marquee outside of the resident's room near the 1 South nurse's station, indicating the call light had been activated. Surveyor alerted LPN-C who verified the call light was not registering on the marquee. LPN-C further verified the call light was not alerting the nursing staff on their radio's that the call light had been activated. The call light system routinely alerts nursing staff on their radios when resident call lights are activated. LPN-C gave R142's bathroom call light to a passing nursing assistant (NA) and asked that she bring it to maintenance for repair. 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. During an observation on 11/3/15, at 1:13 p.m. R33's (room 124) bedroom and bathroom call lights were tested and neither functioned. Nursing assistant (NA)-C was alerted and verified the call lights were not functioning. NA-C continued to test the call lights and after several attempts both call lights eventually functioned and activated the call light system. During an observation on 11/3/15, at 1:51 p.m. R75's (room 136) bedroom call light was tested and did not function. R75 indicated to the surveyor that sometimes the call light cord becomes loose and needs to be pushed back up into the call light box unit. Subsequently, when the surveyor pushed the cord into the box unit, the call light functioned properly.	23010		

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23010	Continued From page 29 On 11/4/15, at 8:30 a.m. R142 was observed seated in recliner 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 lights were 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 that on 11/3/15 after surveyors identified the above call light issues - maintenance staff	23010		

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23010	Continued From page 30	23010		

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 (indicted 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 it 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 1 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

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23010	Continued From page 31	23010		

isn't functioning properly it is to be removed, a duplicate work order is to be filled out, and maintenance will pick up at the nurses station. CM-C further stated when a call light is removed the old call light system is implemented for the affected resident as the previous system is still functional. CM-C confirmed Advanced Wireless Communications emailed daily activity reports indicating call light response times from the previous day. CM-C pulled up the activity report from the previous day for the surveyor to view. The report included the the call light response times and the end of the report also included any maintenance issues. CM-C confirmed she did not address the maintenance section of the report as it was her understanding that maintenance received the same daily report. CM-C further confirmed that nursing was not conducting audits on residents call lights to assure they were functioning properly.

When interviewed on 11/05/15, at 1:47 p.m. CM-B verified she received a daily activity report from Advanced Wireless Communications r/t call light response times from the previous day. CM-B displayed the daily report on her computer for surveyor to review; the report did not include the maintenance section as previously visualized on CM-C 's activity report. CM-B confirmed call light audits were not being performed by nursing on a regular basis. CM-B further stated that when she worked upstairs as a floor nurse would periodically check the call lights as had experienced a resident who had to yell out to staff for help because her call light battery was dead. CM-B stated after that she would do periodic call light checks but had not implemented this practice since moving to her new position on the first floor. CM-B stated when a faulty call light is identified staff are to notify maintenance if still in

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23010	Continued From page 32 the building - if not will deactivate the call light and put in a box downstairs in the bin where the broken call lights are to be placed. If a call light is being repaired the old system will be implemented for the affected resident. When interviewed on 11/5/15, at approximately 2:30 p.m. CM-A stated the ESD had been forwarding the Advanced Wireless Communications daily activity report related to call light response times to her as she was not yet on their email list. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident call lights were kept in proper working order and function. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	23010		