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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5R0N
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 **12/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 5** (L12)

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

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):
CCN--24-5338

Documentation supporting the facility¿s request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 12/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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
Posted 12/22/2014 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **11/19/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245338

December 12, 2014

Mr. Scot Spates, Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, Minnesota 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 November 28, 2014 the above facility is certified for or recommended for:

170 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 170 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: 0067.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 12, 2014

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

RE: Project Number S5338025

Dear Mr. Spates:

On November 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 4, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective November 28, 2014 and therefore remedies outlined in our letter to you dated November 3, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K-0067 at the time of the October 23, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	12/5/2014

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 F0371 Reg. # 483.35(i) LSC	Correction Completed 10/30/2014	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 11/05/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 11/07/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	KS/KFD	12/12/2014	32978	12/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/23/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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 A. Building B. Wing	(Y3) Date of Revisit
245338	01 - MAIN BUILDING 01	12/4/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**11/05/2014**	ID Prefix Reg. # **NFPA 101** LSC K0050	**11/10/2014**	ID Prefix Reg. # **NFPA 101** LSC K0062	**11/28/2014**
ID Prefix Reg. # **NFPA 101** LSC K0069	**10/27/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	12/12/2014	25822	12/04/2014
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
10/21/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5R0N
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 **10/23/2014** (L34)

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**

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B**, 5 (L12)

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

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):

CCN--24-5338

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 11/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0622

November 3, 2014

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

RE: Project Number S5338025

Dear Mr. Spates:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<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
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 2, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 23, 2015 (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 April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, November 12, 2014 10:04 AM
To:	rochi_lsc@cms.hhs.gov
Cc:	gary.schroeder@state.mn.us; 'scot.spates@stjohnsofalbertlea.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	St John's Lutheran Home (245338) 2014 K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that St John's is again requesting an annual waiver for K67, corridors as a plenum. The exit interview was 10-23-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

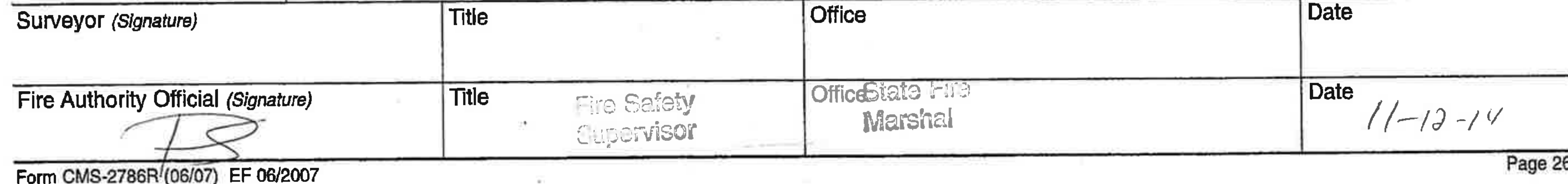
Name of Facility St. John's Lutheran Home of Albert Lea, Albert Lea, MN 56007

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC section 9.2 and NFPA 90A, 1999 ED, because the corridors are being used as a plenum.	A waiver is being requested for K 067 A. Compliance will this provision will cause unreasonable hardship because: 1. The estimated cost of upgrading the facility's HVAC system to comply with NFPA 90A is $906,000. This estimate does not include: electrical, roofing, ceiling modifications, and mechanical design fees. 2. The ceiling tiles that would need to be removed to install required ductwork contain asbestos. The cost of abatement is difficult to estimate. Moreover, this would cause a significant hardship for residents and staff during abatement. 3. The nursing home continues to experience a loss from operations: 2014 loss equals $72,651; 2013 loss equals $265,846; 2012 loss equals $737,652; 2011 loss equals $385,250. See additional information attached.



Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 11-12-14

St John's Luth Hm Albert Lea

B. There will be no adverse effect on the health and safety of the facility's residents and staff because:
   1. The entire building is protected by a supervised automatic sprinkler system installed in accordance with NFPA 13.
   2. The fire alarm system is an addressable system.
   3. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system.
   4. Annual service and maintenance contracts are in place to insure that all of the fire protection systems are operational at all times.
   5. The building fire alarm system is monitored to provide automatic fire department notification.
   6. Fire safety training is provided to all employees on an annual basis and at orientation for new hires.
   7. Fire drills will be conducted at least quarterly on each shift.

C. St. John's master plan includes replacing the existing nursing home within the next five to six years. Replacement of the existing nursing home would happen in two phases.
   1. St. John's applied to the Minnesota Department of Health (MDH) to build a new 84-bed nursing home. The new nursing home will enable St. John's to relocate over 50% of the residents residing at the current facility to the new facility. St. John's was notified on April 22, 2013 by the Minnesota Department of Health that the new nursing home has been approved. Occupancy of the new nursing home is tentatively scheduled for April, 2017. The new nursing home would comply with NFPA 90A.
   2. Phase two of the master plan includes building a second new nursing home within the next five to six years. All residents at the existing site would be relocated to the new nursing home. This building would also be built to comply with NFPA 90A.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING ______ B. WING ______	10/23/2014

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		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the cutting boards and ice machine in a sanitary manner to minimize the possibility of food borne illness. This had the potential to affect all 158 residents currently residing in the facility. Findings include:	F 371	This POC #0371 Correction On 10-22-14, all cutting boards were inspected and all that were deficient were disposed of. On 10-30-14,a dietary staff inservice was held by the Dietary Manager and	10/30/14

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

Electronically Signed — 11/10/2014

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

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F 371	Continued From page 1 During inspection of the kitchen with the dietary manager (DM) on 10/22/14, at 9:47 a.m. 5 of 6 large cutting boards (plastic material) and 1 of 3 small cutting boards (plastic) were identified as having deep groves in them which contained dried food debris. The DM took his fingernail and flicked dried food debris out of the deep groves in the cutting boards. At the same date and time the DM verified the cutting boards needed to be replaced. In addition, the kitchen ice machine was inspected. A ledge located on the inside of the ice machine, had notable black liquid, circular appearing substances throughout. In addition, on each wall inside the machine, near the ice cubes, lime scale build up was identified. On 10/22/14, at 2:03 p.m. dietary aid (DA)-A used a clean, white towel and wiped the ledge located inside the ice machine. The white towel was noted to have black smears across it and on DA-A's knuckles. Using another towel, DA-A attempted to remove the lime scale but the lime scale remained. On 10/22/14, at 2:43 p.m. an interview was conducted with the registered dietitian (RD), DM and the maintenance supervisor (MS). The DM and RD verified that ice had been used from that machine for residents, at least 3 times daily and more often when special events occurred. The above staff further verified they had no idea what the black substance was, as noted on the ledge inside the ice machine. The MS stated that Fountain Refrigeration had cleaned the ice machine on August 6, 2014, per the invoice slip he presented. There was no other evidence available to indicate the ice machine had been routinely cleaned.	F 371	Registered Dietician to review sanitary practices when using cutting boards. An audit will be done weekly for eight weeks and monthy thereafter by the Registered Dietician and the Dietary Manager to check the cutting boards, and sanitary conditions in the kitchen. On 10-22-14, the kitchen ice machine was unplugged and a sign attached to "Do Not Use". A replacement ice machine was installed on 11-07-14. Maintenance will be doing quarterly preventative maintenace on all ice machine and maintaining written records of these preventative measures.	

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F 371	Continued From page 2 On 10/22/14, at 2:43 p.m. the DM stated that when informed of the findings noted on the white towel, the DM and RD immediately shut down the kitchen ice machine. The RD indicated they were in the process of purchasing a new ice machine. Review of the manufacturer's recommendations identified that the ice machine should be cleaned at a minimum of every 6 months, and to ensure economical, trouble free operations of the machine, the following maintenance is required every 3 months: 1. Clean the ice making section... 2. Check ice bridge thickness 3. Check water level in trough 4. Clean the condenser 5. Checks for leaks of any kind; water, refrigerant, oil, etc. 6. Check the bin switch for proper adjustment 7. Check the cam switch setting 8. Check water regulating valve 9. Check to see that the T.X.V. bulb is securely fastened 10. Check all electrical connections 11. Oil fan motor if motor has oil fitting	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		11/5/14

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F 425	Continued From page 3 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that vials of insulin were not available for use after being opened for greater than 30 days for 1 of 6 residents (R103) reviewed who received injectable insulin. Findings Include: During medication storage review on 10/23/14 it was noted that R103's insulin was stored in the medication drawer with a handwritten note dated 9/9/14. This indicated the date the insulin was opened. Registered nurse (RN)-A verified the insulin was 14 days past the outdated limit of 30 days and should have been replaced per facility policy. On 10/22/14, at 2:30 p.m. an interview with RN- D verified she would have expected the date to be checked on the insulin stored in the resident medication drawers by the nurse and replaced at the 30 day expiration period. It was verified the insulin was stored at room temperature.	F 425	This POC #0425 Correction Insulin Vial was immediately dicarded per St. John's Policy and Procedure. All open insulin vials were checked by staff nurses, during the survey, to ensure they had not been open beyond the manufacturers recommendations. Nov. 5, 2014-Licensed nurses received written education on expiration dates of opened insulin vials. Audits to monitor expiration dates of all opened insulin vials will be done weekly x 4 weeks, then monthly until next quarterly QA/QI meeting. Audits will be completed by licensed nurses and submitted to the DON for review. Audit results will be reviewed at the next quarterly QA/QI meeting for further recommendations. On-going random audits will be conducted by the consulting pharmacist.	

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F 425	Continued From page 4 Review of the October 2014 Medication Administration Record (MAR) indicated that R103 received insulin for 10 consecutive days following the 30 day expiration date. This was reviewed and verified by the RN-A. The facility's policy, Pharmaceutical Services Policy & Procedure Manual, indicated multidose parenteral vials should be removed and contents discarded two months from the date of original entry, or discarded per manufacturer's expiration date post entry. Insulin vials stored at room temperature must be discarded 30 days after the date of entry.	F 425		
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.	F 441		11/7/14

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F 441	Continued From page 5 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow proper infection control techniques including handwashing and equipment cleansing, during observation of glucometer blood sugar checks for 2 of 2 residents (R1 & R211) who had glucometer blood sugar monitoring conducted. Findings include: During observation on 10/20/14, at 3:31 p.m. licensed practical nurse (LPN)-B used a universal glucometer (common use) to check a blood sugar (BS) for R211. LPN-B cleansed her hands, applied gloves and prepared the equipment. After LPN-B tested the blood sugar and discarded the test strip and lancet, the glucometer was then cleansed with an alcohol swab. The glucometer was then returned to the counter of the rolling computer on wheels (COW) to be available for another resident who required their blood sugar	F 441	This POC #0441 Correction On Nov. 6, 2014, LPN-B and RN-B were educated on manuacturers recommendations for cleaning and disinfecting blood glucose meters and correct use of gloves and hand washing when performing blood glucose testing. On Nov. 7, 2014, all licensed nurses and TMA's received written education, along with a post-test, on manufacturers recommendations for cleaning and disinfecting blood glucose meters and correct use of gloves and hand washing when performing blood glucose testing Audits to ensure glucometers are being cleaned and disinfected per manufacturer's instructions and correct	

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F 441	Continued From page 6 monitored. LPN-B then completed data entry into the computer with the same donned gloves. After the entry was completed, LPN-B removed the gloves and used hand sanitizer. It was observed on 10/20/14, at 3:40 p.m. that LPN- B entered R1's room, opened the medication storage drawer to locate R1's personal glucometer. When unable to locate the resident's glucometer, LPN-B proceeded to the COW and retrieve the same glucometer used for R211. After the blood sugar was obtained, LPN-B was observed to wipe the glucometer with an alcohol swab and replace it on the counter of the COW. No other sanitization was noted. Upon questioning, LPN-B provided the alcohol swab utilized for cleaning of the glucometer. LPN-B verified she utilized the alcohol swabs for cleaning the glucometer after obtaining blood sugar levels for R1 and R211. It was observed on 10/22/14, at 7:46 a.m. that registered nurse (RN)-B checked a BS for R116. After the blood sugar was checked with donned gloves, RN-B entered data into the computer without a change of gloves and/or hand sanitization. The soiled gloves were not removed when the computer keyboard was accessed. During interview on 10/23/14, at 11:54 a.m. RN-D stated that glucometers should not be used for multiple residents and indicated each resident had their own glucometer. RN-D also stated the glucometers are routinely cleaned with alcohol wipes. During interview on 10/23/14, at 11:56 a.m. LPN -C stated that she indicated there was one glucometer available that could be used as	F 441	use of gloves and hand washing when performing blood glucose tests will be done three times per week for four weeks and then periodically until the next quarterly QA/QI meeting. Audits results will be forwarded to the DON for review and will be reviewed at the next quarterly QA/QI meeting for further recommendations.	

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F 441	Continued From page 7	F 441		

needed to monitor resident blood sugars. This glucometer is stored on the East COW and would be available if a resident did not have their own personal glucometer.

During interview on 10/23/14, at 1:42 p.m. RN-C verified she had routinely used alcohol wipes to clean the glucometers. She further stated she was unaware that alcohol wipes were not a proper disinfectant for cleaning glucometers.

Review of the Policy: Infection Control for Glucometers with Purpose: Prevent resident-to-resident transmission of blood borne pathogens.
Procedure:
1) Glucometers should be assigned to individual residents. If a glucometer that has been used for one resident must be reused for another resident, the device must be cleansed and disinfected.
2) To Clean: Wipe the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol.
3) To Disinfect: Disinfect blood sugar glucometer after each use. Use the PDI SUPER SANI-CLOTH to disinfect the meter after each use.

Review of the ASSURE PLATINUM user instruction manual included: Cleaning & Disinfecting Guidelines: Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe.

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

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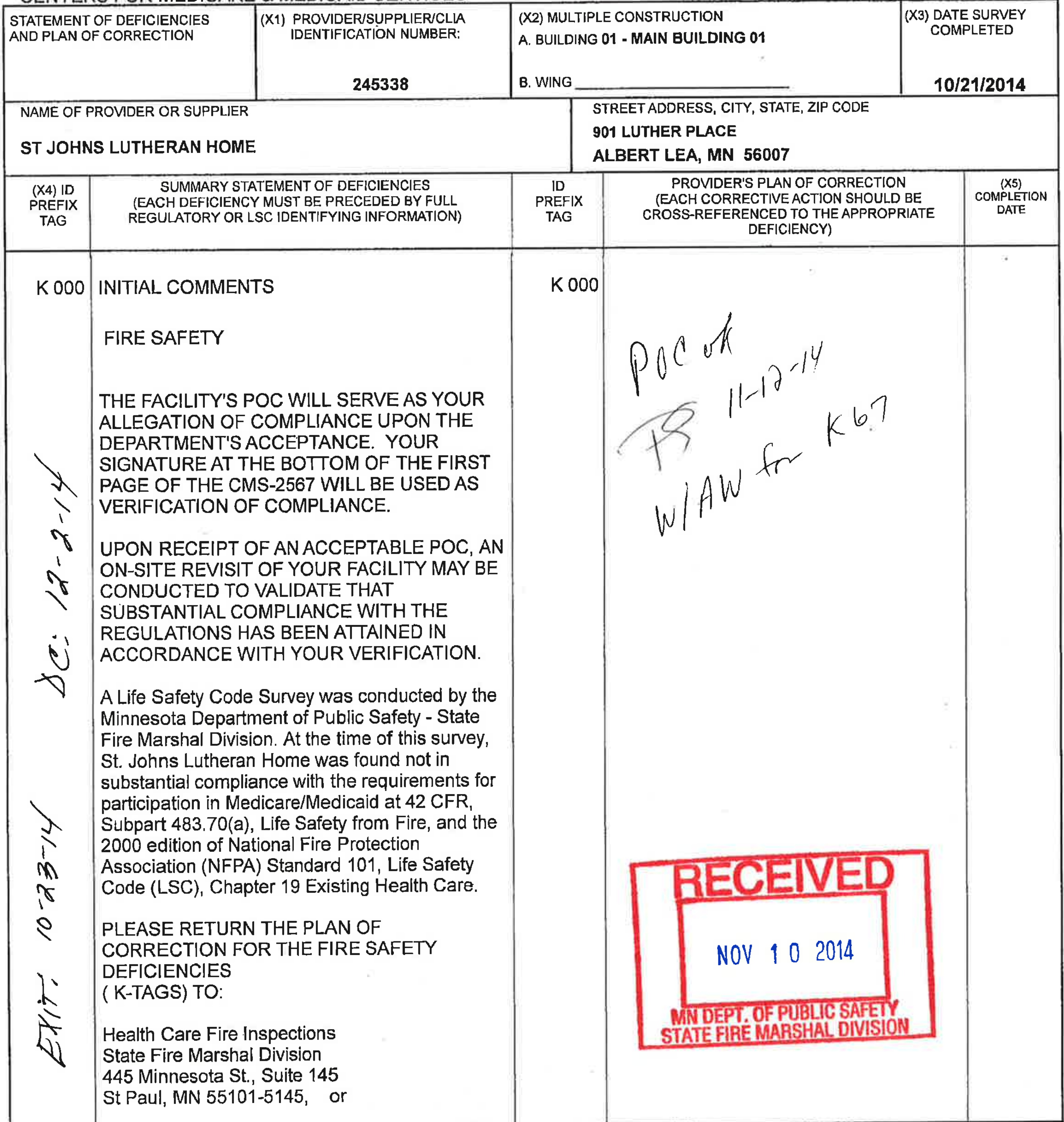

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT 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	POC ok TS 11-12-14 w/AW for K67 RECEIVED NOV 10 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 10-23-14   DC: 12-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot Spates
TITLE: CEO & Administrator
(X6) DATE: 11-10-14

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 170 beds and had a census of 162 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out 162 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 10/21/2014, observation revealed, that the following was found:	K 029	**K029** On 10/23/2014 the soiled utility room door latch was adjusted so that the door would latch. This was completed by the Maintenance Director. The Maintenance Director and Environmental Services Director will monitor door closers and latches once per month during the monthly fire drill, and make appropriate repairs when warranted. On 11/5/2014 a door closer was installed on storage room #123. The Environmental Services Director will monitor for ongoing compliance and report any deficient findings to the Administrator. Repairs will be made promptly.	

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	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/21/2014

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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K 029	Continued From page 3 1. Soiled utility room # 251 - will not shut/latch 2. Storage room # 123 (over 50 sq. ft.) - no automatic door closer This deficient practice was confirmed by the Director of Environmental Services (PM) at the time of discovery.	K 029		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 162 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 10/21/2014, the review of the fire drills reports for October 2013 to September 2014. The following	K 050	K050 The Environmental Services Director will be responsible for scheduling all fire drills at varying times. This practice is effective immediately. The Administrator will monitor for compliance.	11-10-14

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K 050	Continued From page 4 was found: 1. The following fire drills were missed: a. 2013/2014 - 4th quarter - day shift b. 2014 - 1st quarter - day and night shift 2. The drills for the following shifts did not sufficiently vary the times that the drills were conducted: Day: 0910 and 0900 hours Evening: 1610, 1600, 1630 and 1630 hours These deficient practices were confirmed by the Director of Environmental Services (PM) at the time of discovery.	K 050		
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 observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-2.1.1 This deficient practice could affect 25 out of 162 residents Findings include:	K 062	K062 Olympic Fire was contacted to update fire sprinkler heads. On 11/5/2014, the Olympic work order was signed by the Environmental Services Director to replace corroded sprinkler heads. Sprinkler heads will be replaced by Nov. 28, 2014. The Environmental Services Director will monitor for Compliance.	

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K 062	Continued From page 5 On facility tour between 1:00 PM and 4:30 PM on 10/21/2014, observation revealed that the following was found: 1. Kitchen - several sprinkler heads are corroded 2. Kitchen - sprinkler heads have a heavy lint build up on them NOTE: Check the entire facility for this deficiency These deficient practices were confirmed by the Director of Environmental Services (PM) at the time of discovery.	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and documentation review, the facility's general ventilating and air conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 162 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 10/21/2014, observation revealed, that the	K 067	K067 A waiver is being requested and is attached to the plan of correction.	AW

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K 067	Continued From page 6 corridors in the 1960, 1964, and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous years. This deficient practice was confirmed by the Director of Environmental Services (PM) at the time of discovery.	K 067		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not arranged in accordance with 2000 NFPA 101 - Sections 19.3.5 and 9.7 and 1998 NFPA 96 section 9-1.2.2. The deficient practice could affect 15 out of 162 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 10/21/2014, observation of the kitchen hood fire protection system, revealed that the kitchen stove was moved 12 inches to 16 inches back. The kitchen hood fire protection system spray nozzles are now out of alignment and stove is not properly protected. This deficient practice was confirmed by the Director of Environmental Services (PM) at the time of discovery.	K 069	K069 On 10-27-14, the kitchen hood fire protection spray nozzle was adjusted by Fairmont Fire. The Environmental Services Director will monitor for ongoing compliance and make appropriate repairs when warranted.	

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K 069	Continued From page 7 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069		