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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5SVW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00116

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245372**
2.STATE VENDOR OR MEDICAID NO.
(L2) **428540900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUKES LUTHERAN CARE CENTER**
(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

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 **02/24/2015** (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 **108** (L18)

13.Total Certified Beds **108** (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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 02/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/13/2015 (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
12/01/1986
(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
02/26/2015
(L33)

DETERMINATION APPROVAL

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

Page 2
Provider Number: 24-5372
Item 16 Continuation for CMS-1539

Effective April 1, 2015, the number of beds in this facility¿s Medicare certified area are reduced from 108 beds to 104 beds in accordance with a change in licensure. These four beds are being placed on layaway status in accordance with Minnesota Statute 144A.071, Subd. 4b. Please refer to the letter dated February 1, 2015 which was received in this office by email on January 28, 2015, from Erin Farland, Chief Financial Officer.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Delivered Electrically February 26, 2015

CMS Certification Number (CCN): 245372

February 26, 2015

Ms. Margaret Brandt, Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, Minnesota 56013

Dear Ms. Brandt:

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 February 6, 2015 the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

February 24, 2015

Ms. Margaret Brandt, Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, Minnesota 56013

RE: Project Number S5372024

Dear Ms. Brandt:

On January 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 24, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 6, 2015 and therefore remedies outlined in our letter to you dated January 22, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245372	A. Building B. Wing	2/24/2015

Name of Facility	Street Address, City, State, Zip Code
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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 **F0309** Reg. # **483.25** LSC	**02/06/2015**	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	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	02/24/2015	03048	02/24/2015
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
1/8/2015				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245372	ST LUKES LUTHERAN CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 03048	02/24/2015	02/24/2015	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... U

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5SVW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00116

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245372**

2.STATE VENDOR OR MEDICAID NO.
(L2) **428540900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUKES LUTHERAN CARE CENTER**
(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

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 **01/08/2015** (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 **108** (L18)

13.Total Certified Beds **108** (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
	108			
(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 :
Kathy Hahn, HFE NE II 02/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/25/2015 (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
12/01/1986
(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

Certified Mail # 7010 1060 0002 3051 2729

January 22, 2015

Ms. Margaret Brandt, Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, Minnesota 56013

RE: Project Number S5372024

Dear Ms. Brandt:

On January 8, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the 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 February 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 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 July 8, 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 an ePoC for the cited deficiencies.

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
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
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(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 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 review the facility failed to assess and monitor a bruise for 1 of 3 residents (R131) reviewed for non-pressure related skin issues. Findings include: R131 was admitted from an acute care hospital to the facility on 1/2/15 following acute mental changes, hallucinations, and a urinary tract	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING St. Luke□s Lutheran Care Center□s protocol for documentation of bruises is well defined. In this isolated incident, the nursing staff did not follow the facility□s protocol for monitoring and documentation of bruises. Per facility protocol, every resident will	2/6/15

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

Electronically Signed | 02/06/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 infection (UTI). During observation/interview on 1/5/15, at 7:16 p.m. R131 was noted to have a very large blue colored bruise that extended from the tops of the left fingers to several centimeters (cm) above the left wrist and across the entire top of top of left hand. The entire bruised area was swollen when compared to the right hand, lower arm, and fingers. R131 confirmed that she was not able to recall how the bruising had occurred. Subsequent observation/interview on 1/6/15, at 8:08 a.m. identified the bruised area was just below the tops of the left fingers to several cm. above the wrist, across the entire top of the hand and onto the palmer surface below the left 5th finger and appeared swollen. R131 was unable to state how or when she obtained the bruise. During interview with the resident care coordinator, registered nurse (RN)-A on 1/7/15, at 10:35 a.m. stated that R131 was admitted to the facility with the bruise and she felt that the acute care hospital had monitored the bruise, prior to R131's admission to the facility. When interviewed on 1/7/15, at 10:42 a.m. licensed practical nurse (LPN)-A stated that the nursing home had a policy that required all bruises to be monitored for 48 hours after a bruise was identified. Interview with the assistant director of nursing RN-B on 1/7/15, at 10:51 a.m. verified that the Weekly Skin Assessment Form, completed following R131's shower, dated 1/5/15, lacked any information of a bruised area by the certified nursing assistant (CNA) and was not co-signed	F 309	have a full body skin audit completed upon admission and weekly on an ongoing basis. Certain residents may be care planned for daily skin checks by direct care staff at the nurses discretion. Documentation of the skin audit will include any bruises present, and will be recorded on the Admission Assessment Skin Observation Form and Weekly Skin Assessment Form. A Resident Change Documentation Form is generated at the nurses discretion for follow-up monitoring and documentation every shift for bruises of concern including large bruises and/or bruising including but not limited to those with a hematoma, swelling, or pain. Documentation will include size in centimeters, color(s) of bruised area, presence of hematoma or swelling, and resident complaint of tenderness or pain if present. R131 was admitted to St. Lukes Lutheran Care Center on 1/2/15. A full body skin audit was completed upon admission. However, the nursing staff completing the skin audit did not include a measurement in centimeters of the bruise on the residents hand; only location of bruising and note stating L hand mid fingers, all hand. Bruising on residents right thigh and right arm were measured in centimeters. RN Resident Care Coordinator (RN-A) and LPN-A discussed incident with Director of Nursing and stated an understanding of the facilitys protocol for monitoring and documentation of bruising. Nursing staff realized that a Resident Change Documentation Form	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 by a licensed staff, per facility policy. When interviewed on 1/7/15, at 11:21 a.m. RN-A stated that she measured R131's left hand/arm bruised area, that the bruise was bluish in color and measured 20.3 cm. long and 15.3 cm. wide. She further added that the bruise started just below the bottom of the left fingernails to above the wrist and covered the top of the hand and onto the palmer surface under the left 5th finger. Review of the Admission Assessment Skin Observation Form dated 1/2/15, identified a bruised area on R131's left hand which specified the bruise started at the knuckles, ended at the wrist and covered the hand. Review of the temporary care plan dated 1/2/15 specified skin care but lacked information pertaining to monitoring the left hand bruise. Review of the integrated progress notes (IPN) identified the only notation of a bruised area was documented on 1/5/15, timed (7-3) specified "bruising on left hand and right forearm. No other skin issues." Review of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, dated 11/12, identified the following: Every resident will have a full body audit completed upon admission on an ongoing basis. Certain residents may be care planned for daily skin checks by direct care staff at the nurse's discretion. Documentation of the skin audit will include any bruises present, and will be recorded on the Admission Assessment Skin Observation Form and Weekly Skin Assessment Form. ...Documentation following the above protocol will include the following description of bruises: 1. Size measured in centimeters 2. Color(s) of bruised area at time of initial	F 309	should have been generated upon admission for follow-up monitoring and documentation. The Admission Checklist has been updated to include a reminder to nursing staff to generate a Resident Change Documentation Form for bruises that need monitoring upon admission. LPN-A stated that she had not included measurement of bruise on hand because it was difficult to measure; she stated understanding of need to always include a measurement of bruises. As of 1/26/15, R131□s bruise has resolved. On a weekly basis, a licensed nurse performs a full body skin assessment on each resident, noting all bruises and any alteration in skin integrity. Director of Nursing interviewed nurse responsible for completing R131□s skin audit on 1/5/15. Nurse stated that R131□s skin audit was accidently omitted. All Nursing Department licensed staff members are required to attend an in-service session on 2/5/15 or 2/6/15 that will cover the following topic: 1. Review of facility protocol for documentation and monitoring of bruises Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test. On a weekly basis for one month and then on a monthly basis, the Director of Nursing or her designee will randomly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 documentation and at time of follow-up documentation 3. Presence of hematoma, swelling 4. Resident complaint of tenderness or pain if present Interview with the assistant director of nursing RN-B on 1/7/15, at 10:51 a.m. verified that it was the protocol for the staff to measure and monitor any bruised areas for 48 hours after identification and stated she would have expected R131's bruise to have been measured and monitored for 48 hours following admission to the facility.	F 309	audit follow-up documentation for bruising noted upon admission, on Fall Incident Reports, Resident Incident Reports and weekly full body skin assessments to assure that bruise status is monitored and documented. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation. Completion Date: 2/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 06, 2015. At the time of this survey, Building 01 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Building 01 of St. Luke's Lutheran Care Center was constructed as follows: The original building was constructed in 1963, is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1969 building addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1975 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111)construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 99 at time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**01/06/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 06,2015. At the time of this survey, Building 02 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of St. Luke's Lutheran Care Center consists of the 2005 building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 99 at time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **03 - 2008 ADDITION** B. WING _____	**01/06/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 06,2015. At the time of this survey, Building 03 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 03 of St. Luke's Lutheran Care Center consists of the 2008 mechanical building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 99 at time of the survey.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2729

January 22, 2015

Ms. Margaret Brandt, Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, Minnesota 56013

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5372024

Dear Ms. Brandt:

The above facility was surveyed on January 5, 2015 through January 8, 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, Compliance Monitoring 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
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00116	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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

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

Electronically Signed | 02/06/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00116	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 January 5, 6, 7, and 8th 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. THIS WILL APPEAR ON EACH PAGE.	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor a bruise for 1 of 3 residents (R131) reviewed for non-pressure related skin issues. Findings include: R131 was admitted from an acute care hospital to the facility on 1/2/15 following acute mental changes, hallucinations, and a urinary tract infection (UTI). During observation/interview on 1/5/15, at 7:16 p.m. R131 was noted to have a very large blue	2 830	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING St. Luke□s Lutheran Care Center□s protocol for documentation of bruises is well defined. In this isolated incident, the nursing staff did not follow the facility□s protocol for monitoring and documentation of bruises. Per facility protocol, every resident will have a full body skin audit completed upon admission and weekly on an ongoing basis. Certain residents may be care planned for daily skin checks by direct	2/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00116	A. BUILDING: _____ B. WING _____	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 colored bruise that extended from the tops of the left fingers to several centimeters (cm) above the left wrist and across the entire top of top of left hand. The entire bruised area was swollen when compared to the right hand, lower arm, and fingers. R131 confirmed that she was not able to recall how the bruising had occurred. Subsequent observation/interview on 1/6/15, at 8:08 a.m. identified the bruised area was just below the tops of the left fingers to several cm. above the wrist, across the entire top of the hand and onto the palmer surface below the left 5th finger and appeared swollen. R131 was unable to state how or when she obtained the bruise. During interview with the resident care coordinator, registered nurse (RN)-A on 1/7/15, at 10:35 a.m. stated that R131 was admitted to the facility with the bruise and she felt that the acute care hospital had monitored the bruise, prior to R131's admission to the facility. When interviewed on 1/7/15, at 10:42 a.m. licensed practical nurse (LPN)-A stated that the nursing home had a policy that required all bruises to be monitored for 48 hours after a bruise was identified. Interview with the assistant director of nursing RN-B on 1/7/15, at 10:51 a.m. verified that the Weekly Skin Assessment Form, completed following R131's shower, dated 1/5/15, lacked any information of a bruised area by the certified nursing assistant (CNA) and was not co-signed by a licensed staff, per facility policy. When interviewed on 1/7/15, at 11:21 a.m. RN-A stated that she measured R131's left hand/arm bruised area, that the bruise was bluish in color	2 830	care staff at the nurses discretion. Documentation of the skin audit will include any bruises present, and will be recorded on the Admission Assessment Skin Observation Form and Weekly Skin Assessment Form. A Resident Change Documentation Form is generated at the nurses discretion for follow-up monitoring and documentation every shift for bruises of concern including large bruises and/or bruising including but not limited to those with a hematoma, swelling, or pain. Documentation will include size in centimeters, color(s) of bruised area, presence of hematoma or swelling, and resident complaint of tenderness or pain if present. R131 was admitted to St. Lukes Lutheran Care Center on 1/2/15. A full body skin audit was completed upon admission. However, the nursing staff completing the skin audit did not include a measurement in centimeters of the bruise on the residents hand; only location of bruising and note stating L hand mid fingers, all hand. Bruising on residents right thigh and right arm were measured in centimeters. RN Resident Care Coordinator (RN-A) and LPN-A discussed incident with Director of Nursing and stated an understanding of the facilitys protocol for monitoring and documentation of bruising. Nursing staff realized that a Resident Change Documentation Form should have been generated upon admission for follow-up monitoring and documentation. The Admission Checklist has been updated to include a reminder to nursing staff to generate a Resident	

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2 830	Continued From page 4 and measured 20.3 cm. long and 15.3 cm. wide. She further added that the bruise started just below the bottom of the left fingernails to above the wrist and covered the top of the hand and onto the palmer surface under the left 5th finger. Review of the Admission Assessment Skin Observation Form dated 1/2/15, identified a bruised area on R131's left hand which specified the bruise started at the knuckles, ended at the wrist and covered the hand. Review of the temporary care plan dated 1/2/15 specified skin care but lacked information pertaining to monitoring the left hand bruise. Review of the integrated progress notes (IPN) identified the only notation of a bruised area was documented on 1/5/15, timed (7-3) specified "bruising on left hand and right forearm. No other skin issues." Review of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, dated 11/12, identified the following: Every resident will have a full body audit completed upon admission on an ongoing basis. Certain residents may be care planned for daily skin checks by direct care staff at the nurse's discretion. Documentation of the skin audit will include any bruises present, and will be recorded on the Admission Assessment Skin Observation Form and Weekly Skin Assessment Form. ...Documentation following the above protocol will include the following description of bruises: 1. Size measured in centimeters 2. Color(s) of bruised area at time of initial documentation and at time of follow-up documentation 3. Presence of hematoma, swelling 4. Resident complaint of tenderness or pain if present	2 830	Change Documentation Form for bruises that need monitoring upon admission. LPN-A stated that she had not included measurement of bruise on hand because it was difficult to measure; she stated understanding of need to always include a measurement of bruises. As of 1/26/15, R131□s bruise has resolved. On a weekly basis, a licensed nurse performs a full body skin assessment on each resident, noting all bruises and any alteration in skin integrity. Director of Nursing interviewed nurse responsible for completing R131□s skin audit on 1/5/15. Nurse stated that R131□s skin audit was accidently omitted. All Nursing Department licensed staff members are required to attend an in-service session on 2/5/15 or 2/6/15 that will cover the following topic: 1. Review of facility protocol for documentation and monitoring of bruises Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test. On a weekly basis for one month and then on a monthly basis, the Director of Nursing or her designee will randomly audit follow-up documentation for bruising noted upon admission, on Fall Incident Reports, Resident Incident Reports and weekly full body skin assessments to assure that bruise status is monitored and documented. Results of auditing will	

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2 830	Continued From page 5 Interview with the assistant director of nursing RN-B on 1/7/15, at 10:51 a.m. verified that it was the protocol for the staff to measure and monitor any bruised areas for 48 hours after identification and stated she would have expected R131's bruise to have been measured and monitored for 48 hours following admission to the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor bruising and/or bruising present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830	guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation. Completion Date: 2/6/15	
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.	21426		1/28/15

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21426	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Tuberculosis Prevention and Control policy/procedure was updated using current Centers for Disease Control and Prevention (CDC) guidelines and failed to implement these guidelines for 13 of 13 employees (NA-C, RN-X, NA-G, NA-H, RN-F, NA-D, NA-F, DA-A, NA-E, RN-D, NA-A, DA-B and RN-E) hired in the past 12 months and whose employee file was reviewed. This had the potential to impact all residents residing at the facility. Findings include: The facility's "TB Infection Control Protocols", updated 11/2013, indicated: "All employees, unless written documentation of previous positive reaction to a standard intradermal tuberculin test, shall have a baseline TST performed if there is a documented negative TST with one (1) year prior to employment. The test is read 48-72 hours after receiving the injection. For those who do not have a documented negative TST for the preceding 12 months, the baseline TST should employ the two-step method with the first test being read prior to employment and the second test given one to three weeks after the first. This is to include those who have had a BCG vaccination." The Minnesota Department of Health (MDH)	21426	Corrected.	

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21426	Continued From page 7 Tuberculosis Prevention and Control Program, dated 7/2013 indicated: "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated with 90 days before hire. The second TST may be performed after the HCW starts working with patients." Nursing assistant (NA)-C was hired on 4/1/14. Review of the employee file revealed NA-C received a tuberculin skin test (TST) on 9/13/13 (greater than 90 days before hire) from a prior employer. The file lacked evidence that a two-step TST was completed by the facility. Registered nurse (RN)-X was hired on 6/24/14. Review of the employee file revealed RN-X received a TST on 11/25/13 (greater than 90 days before hire) from a prior employer. The file lacked evidence that a two-step TST was completed by the facility. NA-G was hired on 9/9/14. Review of the employee file revealed NA-G received a TST on 5/12/14 (greater than 90 days before hire) from a prior employer. The file lacked evidence that a two-step TST was completed by the facility. NA-H was hired on 9/18/14. Review of the employee file revealed NA-H received a TST on 5/23/14 (greater than 90 days before hire) from a prior employer. The file lacked evidence that a two-step TST was completed by the facility. RN-F was hired on 11/5/14. Review of the employee file revealed RN-F received a TST on 7/17/14 (greater than 90 days before hire) from a prior employer. The file lacked evidence that a two-step TST was completed by the facility.	21426		

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21426	Continued From page 8 NA-D was hired on 4/9/14. Review of the employee file revealed NA-D received a TST on 2/7/14 from a prior employer. The file lacked evidence that a 2nd step TST was completed by the facility. NA-F was hired on 7/8/14. Review of the employee file revealed NA-F received a TST on 4/8/14 from a prior employer. The file lacked evidence that a 2nd step TST was completed by the facility. Dietary aide (DA)-A was hired on 7/22/14. Review of the employee file revealed DA-A received a 1st step TST on 7/22/14 by the facility. The file lacked evidence that a 2nd step TST was completed. NA-E was hired on 5/20/14. Review of the employee file revealed NA-E received a 1st step TST on 5/20/14 by the facility. The file lacked evidence that a 2nd step TST was completed. RN-D was hired on 8/19/14. Review of the employee file revealed RN-D received a 1st step TST on 8/19/14 by the facility. The file lacked evidence that a 2nd step TST was completed. NA-A was hired on 1/8/14. Review of the employee file revealed NA-A received a 1st step TST on 1/8/14 and began floor orientation working with residents on 1/9/14 (less than 48 hours after the TST was administered). DA-B was hired on 8/5/14. Review of the employee file revealed DA-B received a 1st step TST on 8/5/14 and began floor orientation working with residents on 8/6/14 (less than 48 hours after the TST was administered).	21426		

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21426	Continued From page 9 RN-E was hired on 10/28/14. Review of the employee file revealed RN-E received a 1st step TST on 10/29/14 and also began floor orientation working with residents on 10/29/14 (less than 48 hours after the TST was administered). When interviewed on 1/8/15, at 10:04 a.m. the infection control nurse RN-C confirmed that the facility TB policy had not been updated per MDH regulations. RN-C further confirmed that the facility had continued the practice of accepting a documented TST within 12 months prior to hire rather than 90 days and that 2nd step TST's had not been consistently performed. RN-C also confirmed that new employees should not start working on the floor with residents prior to the 1st step TST being read with a negative result. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Tuberculosis screening and testing is done on all staff and residents per CDC guidelines. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures and develop a system to monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		