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: 5SVW Facility ID: 00116

	=========						Tuemey 15. corre	
MEDICARE/MEDICAID PROVIDE (L1) 245372	ER NO.	3. NAME AND AI (L3) ST LUKES			NTER	4. TYPE OF ACTION	 ·	
2.STATE VENDOR OR MEDICAID N	IO.	(L4) 1219 SOUTI	H RAMSEY			1. Initial	2. Recertification	
(L2) 428540900		(L5) BLUE EAR			(L6) 56013	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG		<u>02</u> (L7)	7. On-Site Visit 8. Full Survey Afte	9. Other	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	0. 1 an sai vey 11.0	- Companie	
6. DATE OF SURVEY 02/28. ACCREDITATION STATUS:	4/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/III	14 CORF D 15 ASC	FISCAL YEAR END	ING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	Y IS CERTIFIED	AS:				
From (a):		X A. In Complia	ince With		And/Or Approved Waivers Of		nents:	
To (b):			equirements be Based On:		2. Technical Personnel3. 24 Hour RN	6. Scope of S 7. Medical D		
12.Total Facility Beds	108 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		om Size	
13.Total Certified Beds	108 (L17)		npliance with Progents and/or Appli			(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
108					3 , (,			
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Kathryn Serie, Unit Superv	risor	0	02/24/2015	(L19)	Kamala Fiske-Downing.	Enforcement Spe	cialist 03/13/2015 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	, ,	
19. DETERMINATION OF ELIGIBII	JTY		MPLIANCE WITH	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to I	Participate	RIGHTS ACT:			 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	NTARY	
12/01/1986					01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	der Status Change	
(L27)			(L44)			00-Active	9	
(L21)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY/	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION	N OF APPROVAI	DATE				
	52	02/26/2015		_				
	(L32)			(L33)	DETERMINATION APP	ROVAL		

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: 5SVW Facility ID: 00116

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

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

Page 2

Effective April 1, 2015, the number of beds in this facility & 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.



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.

St Lukes Lutheran Care Center February 26, 2015 Page 2

Sincerely,

Kamala Fiske Downing

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



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.

St Lukes Lutheran Care Center February 24, 2015 Page 2

Feel free to contact me if you have questions.

Sincerely,

Kamala Fishe Downing

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

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 245372	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/24/2015
Name	e of Facility		Street Address, City, State, Zip Code	
ST	LUKES LUTHERAN CARE CENTER	R	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	(Y4) Item	(Y5)	Date	(Y4)	Item	()	/ 5)	Date
ID Prefix	F0309	Correction Completed 02/06/2015	ID Prefix		Correction Completed		ID Prefix			Correction Completed
Reg. # LSC	483.25	_	Reg. #				Reg. # _ LSC _			
Reg. #			Reg. #		Correction Completed					Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed					Correction Completed
Reg. #			Reg. #				D			
Reviewed E	By Reviewed	d By	Date:	Signature of Sur	veyor:				Date:	
State Agend	KS/kfd		02/24/2015			0304	18		0	2/24/2015
Reviewed E			Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Completed o	n:		Check for any Uncor Uncorrected Defic					YES	NO

U

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

245372	Number		vider/Supplie LUKES LUTHER <i>A</i>		ER			
Type of Survey (selection of Survey (Selection)			A Complaint B Dumping In C Federal Mo D Follow-up A Routine/St	vestigation nitoring Visit	F Inspec G Valida H Life s	tion of Car tion afety Code	re J San	certification ction/Hearing te License w
D			B Extended S C Partial Ex D Other Surv	tended Surve	_	care facil	ity)	
		1	SURVEY TEAM A	ND WORKLOAD	DATA			
Please enter the work Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	veyor's info On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)		Off-Site Report Preparation Hours (I)
Team Leader 1. 03048	02/24/2015		0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.		1						

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

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: 5SVW Facility ID: 00116

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 (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
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital	F 14 CORF CF/IID 15 ASC	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 108 (L18) 13.Total Certified Beds 108 (L17)	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Wa	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 108 (L37) (L38) (L39)	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Kathy Hahn, HFE NE II PART II - TO BE (19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	Date: 02/23/2015 (L COMPLETED BY HCFA REGIO 20. COMPLIANCE WITH CIVI RIGHTS ACT:	NAL OFFICE OR SINGLE S L 21. 1. Statement of Final	Enforcement Specialist 02/25/2015 (L20) TATE AGENCY notial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
A. Suspension (L27) B. Rescind St	(L25) VE SANCTIONS In of Admissions: (L44) uspension Date: (L45) D. INTERMEDIARY/CARRIER NO.	26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	INVOLUNTARY 05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement
(L28) 31. RO RECEIPT OF CMS-1539 (L32)	03001 (L3 2. DETERMINATION OF APPROVAL DATE (L3	3	ROVAL



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

<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 <u>Kathryn.serie@state.mn.us</u> 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

St Lukes Lutheran Care Center January 22, 2015 Page 4

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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.

St Lukes Lutheran Care Center January 22, 2015 Page 5

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

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

Enclosure

PRINTED: 02/10/2015 FORM APPROVED OMB NO. 0938-0391

-	AND DUAN OF CODDECTION DEPARTMENT AND ALL MADED.		,	COMPLETED	
		245372	B. WING		01/08/2015
	PROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 000		
	as your allegation of Department's acception enrolled in ePOC, yat the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 of submission of the POC will ion of compliance.			
F 309 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with CARE/SERVICES FOR EING	F 309		2/6/15
	provide the necessor maintain the high mental, and psychological provides the provides and provides the provi	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment			
	by: Based on observat review the facility fa bruise for 1 of 3 res non-pressure relate Findings include: R131 was admitted the facility on 1/2/15	ion, interview and document illed to assess and monitor a idents (R131) reviewed for ed skin issues. from an acute care hospital to 5 following acute mental ions, and a urinary tract		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, t nursing staff did not follow the facility protocol for monitoring and documentate of bruises. Per facility protocol, every resident will	s he s
ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

TITLE

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.

PRINTED: 02/10/2015 FORM APPROVED OMB NO. 0938-0391

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245372	B. WING		01/08/2015	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 309	infection (UTI). During observation p.m. R131 was not colored bruise that left fingers to sever left wrist and acroshand. The entire compared to the rifingers. R131 correcall how the bruing subsequent observations and onto the palm finger and appearate to state how or who will be provided in the provided facility with the bruing interview with the provided facility with the bruing interview with the provided facility with the bruing interview with the provided facility with the bruing home had bruises to be mon bruise was identification of the provided facility with the provided f	n/interview on 1/5/15, at 7:16 ted to have a very large blue t extended from the tops of the tral centimeters (cm) above the set the entire top of top of left bruised area was swollen when the set that she was not able to sing had occurred. The vation/interview on 1/6/15, at the left fingers to several cm. bruised area was just the left fingers to several cm. bross the entire top of the hand for surface below the left 5th end swollen. R131 was unable then she obtained the bruise. The vation/interview on 1/6/15, at the left fingers to several cm. bruises the entire top of the hand for surface below the left 5th end swollen. R131 was unable then she obtained the bruise. The vation/interview on 1/6/15, at the left fingers to several cm. bruises the entire top of the hand the swollen. R131 was unable then she obtained the bruise. The vation/interview on 1/6/15, at the left fingers to several cm. bruises the left fingers to several cm. bruises the left fingers to several cm. bruises. The vation/interview on 1/6/15, at the left fingers to several cm. bruises the left fingers to several cm. bruises. The vation/interview on 1/6/15, at the left fingers to several cm. bruises the left finger	F 309	have a full body skin audit complet upon admission and weekly on an ongoing basis. Certain residents in care planned for daily skin checks direct care staff at the nurses dis Documentation of the skin audit wi include any bruises present, and we recorded on the Admission Assess Skin Observation Form and Weekl Assessment Form. A Resident Ch Documentation Form is generated nurse sdiscretion for follow-up monitoring and documentation ever for bruises of concern including lar bruises and/or bruising including be limited to those with a hematoma, swelling, or pain. Documentation winclude size in centimeters, color(sbruised area, presence of hemator swelling, and resident complaint of tenderness or pain if present. R131 was admitted to St. Luke shody skin audit was completed upon admission. However, the nursing scompleting the skin audit did not in measurement in centimeters of the on the resident shand; only location bruising and note stating L hand mingers, all hand. Bruising on resident contimeters. RN Resident Care Coordinator (RN-A) and LPN-A dis incident with Director of Nursing ar stated an understanding of the facing protocol for monitoring and docum of bruising. Nursing staff realized Resident Change Documentation.	nay be by cretion. II ill be ment y Skin ange at the ry shift ge ut not will of na or A full on staff clude a bruise on of id ent sured cussed and lity sentation that a	

PRINTED: 02/10/2015 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			01/0	08/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	0.77	
				1	219 SOUTH RAMSEY		
ST LUKE	S LUTHERAN CARE	CENTER		E	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	by a licensed staff, When interviewed stated that she me bruised area, that tand measured 20.3 She further added below the bottom of the wrist and cover onto the palmer sure Review of the Adm Observation Form bruised area on R1 the bruise started a wrist and covered the Beview of the temps specified skin care pertaining to monit Review of the integidentified the only redocumented on 1/5 "bruising on left haskin issues." Review of the PRC AND DOCUMENT 11/12, identified the have a full body au on an ongoing bas care planned for dastaff at the nurse's the skin audit will in and will be recorded Assessment Skin C Skin Assessment Following the above following description	per facility policy. on 1/7/15, at 11:21 a.m. RN-A asured R131's left hand/arm the bruise was bluish in color 3 cm. long and 15.3 cm. wide. that the bruise started just of the left fingernails to above red the top of the hand and rface under the left 5th finger. ission Assessment Skin dated 1/2/15, identified a 131's left hand which specified at the knuckles, ended at the the hand. For any care plan dated 1/2/15 but lacked information oring the left hand bruise. Instance of a bruised area was 5/15, timed (7-3) specified and and right forearm. No other area of the completed upon admission is. Certain residents may be ally skin checks by direct care discretion. Documentation of a bruises present, and on the Admission Observation Form and Weekly formDocumentation of protocol will include the	F3	809	should have been generated upon admission for follow-up monitoring documentation. The Admission Ch has been updated to include a reminursing staff to generate a Residen Change Documentation Form for bothat need monitoring upon admission LPN-A stated that she had not inclume assurement of bruise on hand be it was difficult to measure; she state understanding of need to always in measurement of bruises. As of 1/2 R131 shruise has resolved. On a weekly basis, a licensed nurse performs a full body skin assessment each resident, noting all bruises an alteration in skin integrity. Director Nursing interviewed nurse responsicompleting R131 shin audit on 1 Nurse stated that R131 shin audit on 1 Nurse stated that R131 shin audit accidently omitted. All Nursing Department licensed stamembers are required to attend an in-service session on 2/5/15 or 2/6/will cover the following topic: 1. Review of facility protocol for documentation and monitoring of both Staff members who are unable to a will be required to read a packet coin-service material and complete a test. On a weekly basis for one month an on a monthly basis, the Director of	ecklist inder to it ruises on. ided cause ed clude a e6/15, eent on d any of ible for /5/15. lit was aff at that ruises attend vering post	

PRINTED: 02/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
		245372	B. WING			01/0	08/2015
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER		12	REET ADDRESS, CITY, STATE, ZIP CODE 119 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	documentatio 3. Presence of h 4. Resident compresent Interview with the a RN-B on 1/7/15, at the protocol for the any bruised areas f and stated she wou bruise to have been	at time of follow-up	F3	09	audit follow-up documentation for be noted upon admission, on Fall Incic Reports, Resident Incident Reports weekly full body skin assessments assure that bruise status is monitor documented. Results of auditing we guide future compliance monitoring training. In addition, the results will summarized at the quarterly Quality Assessment and Assurance Comme Meeting. After 1 year, the Quality Assessment and Assurance Comme will re-evaluate the need and frequent for continued compliance monitoring. The Director of Nursing is responsitive overall compliance with this regulate. Completion Date: 2/6/15	dent s and to red and vill g and be y nittee ency ig.	

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

Printed: 02/11/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	01 - MAIN BUILDING 01	COMPLETED					
		245372		B. WING		01/06	6/2015		
	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE					
ST LUKE	ES LUTHERAN CAR	RE CENTER		OUTH RAM EARTH, MN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
K 000	INITIAL COMMENT	ΓS		K 000					
	FIRE SAFETY								
	Minnesota Departmenter Fire Marshal Division the time of this surve Lutheran Care Censubstantial compliance participation in Medicular Subpart 483.70(a), 2000 edition of Nation Association (NFPA) Code (LSC), Chap Occupancies. Building 01 of St. Line was constructed as The original building one-story in height, fully fire sprinkler put to be of Type II (111 The 1969 building a has no basement, it and was determine construction; The 1975 building a has no basement, it and was determine (111) construction. The facility has a find detection in the conto the corridors, where department notions is the contour of the corridors, where department notions is the contour of the corridors, where department notions.	g was constructed in has a partial basem rotected, and was de l) construction; addition is one-story s fully fire sprinkler pd to be of Type II (11 addition is one-story s fully fire sprinkler pd to be of Type II was addition in the sprinkler pd to be of Type II additions and in all spacific is monitored for a diffication.	Center 1963, is etermined in height, protected, 1) in height, protected smoke ces open automatic						
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	NTATIVE'S SIGI	NATURE	TITLE		(X6) DATE		

(X2) MULTIPLE CONSTRUCTION

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.

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 02/11/2015 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - BUILDING 2 COMPLETED 245372 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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.

(X2) MULTIPLE CONSTRUCTION

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.

(X6) DATE

TITLE

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

F5372024

Printed: 01/08/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 03 - 2008 ADDITION

(X3) DATE SURVEY COMPLETED

245372

B. WING

01/06/2015

NAME OF PROVIDER OR SUPPLIER

ST LUKES LUTHERAN CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1219 SOUTH RAMSEY BLUE EARTH, MN 56013

	BLUE E	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	K 000		
	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.			j
	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.			
	-			
DODATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

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

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

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

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

PRINTED: 02/10/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00116	B. WING		01/08/2	2015
	PROVIDER OR SUPPLIER	CENTER 1219 SOU	DRESS, CITY, S TH RAMSEN RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficition herein are not corrected shall light to the survey of the su	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/infe licensing orders are		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

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

Electronically Signed 02/06/15

TITLE

STATE FORM 6899 If continuation sheet 1 of 10 5SVW11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00116	B. WING		01/08	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER	UTH RAMSE ARTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's sand the following correction that you and identify the date. Minnesota Department's the State Licensing federal software. To assigned to Minnesota Department's sand identify the date. The assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of commany Statement of the Statement of	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. I, and 8th 2015, surveyors of taff, visited the above provider orrection orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting Correction Orders using ag numbers have been not a state statutes/rules for the ent of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis also includes the nis column also includes the nis column also in		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met at evidenced by." Following the surfindings are the Suggested Method Correction and the Time Period Following the States DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF THIS O DN FOR	
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	I WHICH STATES, N OF CORRECTION." THIS				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			(3) DATE SURVEY COMPLETED	
		00116	B. WING		01/0	8/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER	TH RAMSE RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 2 2 000					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			2/6/15
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observation review the facility factorise for 1 of 3 resonon-pressure related. Findings include: R131 was admitted the facility on 1/2/15 changes, hallucination (UTI). During observation/	ent is not met as evidenced on, interview and document illed to assess and monitor a idents (R131) reviewed for d skin issues. from an acute care hospital to following acute mental ions, and a urinary tract interview on 1/5/15, at 7:16 ed to have a very large blue		F309 PROVIDE CARE/SERVICES HIGHEST WELL BEING St. Luke S Lutheran Care Center protocol for documentation of bruis well defined. In this isolated incide nursing staff did not follow the faci protocol for monitoring and docum of bruises. Per facility protocol, every residentave a full body skin audit comple admission and weekly on an ongo basis. Certain residents may be oplanned for daily skin checks by displacements.	sses is ent, the lityssentation twill ted upon ing are	

Minnesota Department of Health

STATE FORM 5899 5SVW11 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		00116	B. WING	····	01/08/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
ST LUKE	S LUTHERAN CARE	CENTER	TH RAMSE' RTH, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 830	Continued From pa	ge 3	2 830		
2 830	colored bruise that left fingers to sever left wrist and across hand. The entire b compared to the rig fingers. R131 conf recall how the bruis. Subsequent observents: Subsequent obse	extended from the tops of the al centimeters (cm) above the state entire top of top of left ruised area was swollen when the hand, lower arm, and irmed that she was not able to sing had occurred. Tation/interview on 1/6/15, at the bruised area was just the left fingers to several cm. Toss the entire top of the hand or surface below the left 5th diswollen. R131 was unable the she obtained the bruise. The the resident care are the red nurse (RN)-A on 1/7/15, at that R131 was admitted to the se and she felt that the acute the nonitored the bruise, prior to	2 830	care staff at the nurses discretion Documentation of the skin audit winclude any bruises present, and winclude any bruises of concern and Week Assessment Form. A Resident Cl Documentation Form is generated nurse sidescretion for follow-up monitoring and documentation ever for bruises of concern including labruises and/or bruising including blimited to those with a hematoma, swelling, or pain. Documentation include size in centimeters, color(struised area, presence of hematoms swelling, and resident complaint of tenderness or pain if present. R131 was admitted to St. Luke sutheran Care Center on 1/2/15. body skin audit was completed up admission. However, the nursing completing the skin audit did not in measurement in centimeters of the on the resident shand; only local	ill vill be sment ly Skin nange I at the ery shift rge out not will s) of ma or f A full on staff nclude a e bruise
	nursing home had a	a policy that required all ored for 48 hours after a		bruising and note stating L hand n fingers, all hand. Bruising on resident thigh and right arm were measurements. RN Resident Care	nid dent⊡s
	RN-B on 1/7/15, at Weekly Skin Asses following R131's shany information of a nursing assistant (0 by a licensed staff,	ssistant director of nursing 10:51 a.m. verified that the sment Form, completed ower, dated 1/5/15, lacked a bruised area by the certified CNA) and was not co-signed per facility policy.		Coordinator (RN-A) and LPN-A disincident with Director of Nursing a stated an understanding of the factor protocol for monitoring and docum of bruising. Nursing staff realized Resident Change Documentation should have been generated upor admission for follow-up monitoring documentation. The Admission C	nd cility□s nentation I that a Form I
		asured R131's left hand/arm		has been updated to include a ren	

Minnesota Department of Health

STATE FORM 5899 5SVW11 If continuation sheet 4 of 10

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STLUKES LUTHERAN CARE CENTER 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 (XA) ID (XA) ID (REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG 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 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 tiengrated progress notes (IPN) identified the only notation of a bruised area was documented on 1/5/15, immed (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 Form and Weekly Processors of 10 street of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the will be recorded on the Admission Assessment Skin Observation Form and Weekly Processors of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the processor of the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, cated and the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, and the processor of the PROTOCOL FOR MONITORING AND DOCUMENTATION OF BRUISES, dated the pro	Minneso	Minnesota Department of Health							
NAME OF PROVIDER OR SUPPLIER STILUKES LUTHERAN CARE CENTER 1219 SOUTH RAMSEY BLUE EARTH, MN 36013 [XA) ID [XA) ID [ACACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION] 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 fingernalis 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 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									
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STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH DEFICIENCY MUST BE PRECEDED BY PULL FARD, MR 56013 (EACH OBRECTIVE ACTION SHOULD BE COMPLETE CATION SHOULD B			00116	B WING		01/00/0015			
CALL DEPICIENCY SUMMARY STATEMENT OF DEFICIENCIES BLUE EARTH, MN 56013						<u> U1/U</u>	0/2013		
XALID XAL	NAME OF I	PROVIDER OR SUPPLIER							
X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) PREFIX TAG PREVIOUS PROVIDED	ST LUKE	S LUTHERAN CARE	CENTER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 fingernalis 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 in-service material and complete a post			BLUE EA		T				
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	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE	COMPLETE		
She further added that the bruise started just below the bottom of the left fingernalls 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 bruises darea 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." Haview 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 in the wrist and covered the hand. Review of the Emporary care plan dated 1/2/15 measurement of bruises. As of 1/26/15, R131 shin suclid to a measurement of bruises it was difficult to measure; she stated understanding of need to always include a measurement of bruises. As of 1/26/15, R131 shin shin include any serice has a provise on passes it was difficult to measure; she stated understanding of need to always include a measurement of bruises. As of 1/26/15, R131 shin sclude it was difficult to measure; she stated understanding of need to always include a measurement of bruises. As of 1/26/15, R131 shin suclided to always include a measurement of bruises. As of 1/26/15, R131 shin suclided to always include a measurement of bruises. As of 1/26/15, R131 shin suclided to always include a measurement of bruises. As of 1/26/15, R131 s	2 830	Continued From pa	age 4	2 830					
Skin Assessment FormDocumentation 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 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	2 830	and measured 20.3 She further added to below the bottom of the wrist and covered onto the palmer sur Review of the Admi Observation Form of bruised area on R1 the bruise started a wrist and covered the Review of the temp specified skin care pertaining to monitor Review of the integuidentified the only indocumented on 1/5 "bruising on left har skin issues." Review of the PRO AND DOCUMENTA 11/12, identified the have a full body aud on an ongoing basis care planned for dastaff at the nurse's of the skin audit will in and will be recorded Assessment Skin Oskin Assessment Following the above following description 1. Size measure 2. Color(s) of brudocumentation and documentation 3. Presence of his	S cm. long and 15.3 cm. wide. that the bruise started just of the left fingernails to above ed the top of the hand and rface under the left 5th finger. ission Assessment Skin dated 1/2/15, identified a 31's left hand which specified at the knuckles, ended at the he hand. Forary care plan dated 1/2/15 but lacked information boring the left hand bruise. In the left hand bruise area was 5/15, timed (7-3) specified and and right forearm. No other are following: Every resident will dit completed upon admission so Certain residents may be ally skin checks by direct care discretion. Documentation of a bruises present, don'the Admission Doservation Form and Weekly formDocumentation of a protocol will include the most bruises: ed in centimeters uised area at time of initial at time of follow-up on mematoma, swelling	2 830	that need monitoring upon admiss LPN-A stated that she had not incl measurement of bruise on hand be it was difficult to measure; she star understanding of need to always in measurement of bruises. As of 1/R R131 shruise has resolved. On a weekly basis, a licensed nurse performs a full body skin assessmeach resident, noting all bruises an alteration in skin integrity. Director Nursing interviewed nurse response completing R131 skin audit on Nurse stated that R131 skin audit accidently omitted. All Nursing Department licensed sembers are required to attend an in-service session on 2/5/15 or 2/6 will cover the following topic: 1. Review of facility protocol for documentation and monitoring of the Staff members who are unable to will be required to read a packet of in-service material and complete a test. On a weekly basis for one month a on a monthly basis, the Director of or her designee will randomly audit follow-up documentation for bruisin upon admission, on Fall Incident Resident Incident Reports and weekly basis for one weekly basis for one succession of the service of the designee will randomly audit follow-up documentation for bruisin upon admission, on Fall Incident Resident Incident Reports and weekly basis for one month and the service of the designee will randomly audit follow-up documentation for bruisin upon admission, on Fall Incident Resident Incident Reports and weekly basis for one month and the service material and complete and the service material and the service material and the service material and the	ion. uded ecause ted nclude a 26/15, se ent on nd any r of sible for 1/5/15. dit was taff n s/15 that bruises attend overing a post and then i Nursing t ng noted Reports, ekly full			

STATE FORM 6899 If continuation sheet 5 of 10 5SVW11

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00116	B. WING	·····	01/0	8/2015
	PROVIDER OR SUPPLIER	CENTER 1219 SOL	DRESS, CITY, SITH RAMSE' RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 830	Interview with the a RN-B on 1/7/15, at the protocol for the any bruised areas frand stated she would bruise to have been 48 hours following a SUGGESTED MET. The director of nurseducate all licensed bruising and/or brui upon admission to the nursing could development of the superior of	ssistant director of nursing 10:51 a.m. verified that it was staff to measure and monitor or 48 hours after identification and have expected R131's a measured and monitored for admission to the facility. THOD OF CORRECTION: Sing, or designee, could a staff on the need to monitor sing present on residents the facility. The director of op an audit to monitor staff	2 830	guide future compliance monitoring training. In addition, the results wil summarized at the quarterly Qualit Assessment and Assurance Comm Meeting. After 1 year, the Quality Assessment and Assurance Comm will re-evaluate the need and frequicontinued compliance monitoring. The Director of Nursing is responsitive overall compliance with this regulation. Completion Date: 2/6/15	I be y nittee nittee ency for	
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.	21426			1/28/15

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00116	B. WING		01/0	8/2015
	PROVIDER OR SUPPLIER	CENTER 1219 SOU	DRESS, CITY, S ITH RAMSE' RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 6	21426			
	by: Based on interview facility failed to ensure Prevention and Corupdated using curre Control and Preven failed to implement employees (NA-C, NA-D, NA-F, DA-A, and RN-E) hired in whose employee fill potential to impact a facility. Findings include: The facility's "TB In updated 11/2013, in unless written docureaction to a standard shall have a baselind documented negatifus to employment. The after receiving the innot have a docume preceding 12 month employ the two-step being read prior to test given one to the is to include those waccination."	and document review, the ure the Tuberculosis atrol policy/procedure was ent Centers for Disease tion (CDC) guidelines and these guidelines for 13 of 13 RN-X, NA-G, NA-H, RN-F, NA-E, RN-D, NA-A, DA-B the past 12 months and e was reviewed. This had the all residents residing at the all residents residing at the rest is read 48-72 hours and the test is read 48-72 hours and the second ree weeks after the first. This who have had a BCG		Corrected.		

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00116	B. WING		01/0	8/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STILIKES LITHERAN CARE CENTER			TH RAMSE\ RTH, MN 56			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 7	21426			
	dated 7/2013 indica working with patien symptom screen (i. disease) and a neg step) dated with 90 TST may be perform working with patien					
	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.					
	employee file revea 5/12/14 (greater that prior employer. The	9/9/14. Review of the led NA-G received a TST on an 90 days before hire) from a e file lacked evidence that a completed by the facility.				
	employee file revea 5/23/14 (greater that prior employer. The	9/18/14. Review of the led NA-H received a TST on an 90 days before hire) from a e file lacked evidence that a completed by the facility.				
	employee file reveation 7/17/14 (greater that prior employer. The	11/5/14. Review of the alled RN-F received a TST on an 90 days before hire) from a se file lacked evidence that a completed by the facility.				

Minnesota Department of Health

STATE FORM 5899 5SVW11 If continuation sheet 8 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00116	B. WING		01/	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER	OUTH RAMSE\ ARTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 8	21426			
	employee file revea 2/7/14 from a prior	4/9/14. Review of the led NA-D received a TST on employer. The file lacked I step TST was completed by				
	employee file revea 4/8/14 from a prior	7/8/14. Review of the led NA-F received a TST on employer. The file lacked step TST was completed by				
	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.					
	employee file revea TST on 5/20/14 by	5/20/14. Review of the led NA-E received a 1st step the facility. The file lacked I step TST was completed.				
	employee file revea TST on 8/19/14 by	8/19/14. Review of the lled RN-D received a 1st step the facility. The file lacked I step TST was completed.				
	employee file revea TST on 1/8/14 and working with reside	1/8/14. Review of the led NA-A received a 1st step began floor orientation nts on 1/9/14 (less than 48 was administered).				
	employee file revea TST on 8/5/14 and working with reside	8/5/14. Review of the led DA-B received a 1st step began floor orientation nts on 8/6/14 (less than 48 was administered).				

Minnesota Department of Health

STATE FORM 5899 5SVW11 If continuation sheet 9 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY LETED	
		00116	B. WING		01/0	8/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST LUK	ES LUTHERAN CARE	CENTER	JTH RAMSE` RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 9	21426			
	employee file reveal TST on 10/29/14 ar working with reside hours after the TST. When interviewed of infection control number facility TB policy has regulations. RN-C facility had continued documented TST working and been consistent confirmed that new working on the floor step TST being reasonable step TST being reasonable step TST being reasonable step is done on a guidelines. The Director of Number for the Director of N	10/28/14. Review of the pled RN-E received a 1st step and also began floor orientation into on 10/29/14 (less than 48 was administered). In 1/8/15, at 10:04 a.m. the rese RN-C confirmed that the donot been updated per MDH further confirmed that the ed the practice of accepting a within 12 months prior to hire and that 2nd step TST's had ally performed. RN-C also employees should not start with residents prior to the 1st downth a negative result. IHOD OF CORRECTION: sing or designee could d/or revise policies and re Tuberculosis screening and all staff and residents per CDC ector of Nursing or designee oppropriate staff on the policies doevelop a system to monitor expression. R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM