#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 7RBT

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Faci	lity ID: 00571	
1. MEDICARE/MEDICAID PROVIDE (L1) 245067 2.STATE VENDOR OR MEDICAID N (L2) 470618800		3. NAME AND AL (L3) ST LUCAS ( (L4) 500 SOUTH (L5) FARIBAULT	CARE CENTI EAST FIRST	ER	(L6)	55021	<ol> <li>Initial</li> <li>Termin</li> <li>Validat</li> </ol>	ion	7 (L8) 2. Recertification 4. CHOW 6. Complaint	n
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) <b>13 PTIP</b>	22 CLIA	7. On-Site 8. Full Su	e Visit rvey After Co	9. Other	
6. DATE OF SURVEY 07/07 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEA		DATE: (L35	5)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	109 (L18) 109 (L17)	Complianc1. A		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	oved Waivers Of ' nnical Personnel Iour RN ny RN (Rural SN Safety Code	6. Sc7. Me	Requirements ope of Servic edical Directo tient Room Si eds/Room	es Limit or	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY M	MEETS				
18 SNF 18/19 SNF 109	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L	.15)		
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL		Date:	
Gayle Lantto, Unit S	upervisor	0	7/07/2015	(L19)	Mark"	Meath,	Enforcemen	nt Specialis	07/09/2015	5 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OF	R SINGLE S	TATE AGE	NCY		
19. DETERMINATION OF ELIGIBIDATE  _X 1. Facility is Eligible to I	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. (	Statement of Finar Ownership/Contro Both of the Above	l Interest Disclo		FA-1513)	
2. Facility is not Eligible	(L21)									
22. ORIGINAL DATE OF PARTICIPATION 01/01/1967	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINA  VOLUNTARY  01-Merger, Clos	TION ACTION:  00	_	(L30 NVOLUNTA	RY	
(L24)	(L41)		(L25)		_	on W/ Reimburse		6-Fail to Mee	t Health/Safety	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	untary Terminatio for Withdrawal	<u>(</u>	<u>OTHER</u> 17-Provider St 10-Active	atus Change	
(L27)	B. Rescind St	ispension Date:	J. 45)							
28. TERMINATION DATE:	20	. INTERMEDIARY/	(L45)		30. REMARKS					
20. TERMINATION DATE.	29	03001	CARRIER NO.		JO. KEMAKKS					
	(L28)	03001		(L31)						
31. RO RECEIPT OF CMS-1539		. DETERMINATION 06/17/2015	OF APPROVAI	LDATE						
	(L32)			(L33)	DETERMIN	ATION APPI	ROVAL			



#### Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245067

July 9, 2015

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

Dear Ms. Acosta:

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 June 23, 2015 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



#### Protecting, Maintaining and Improving the Health of Minnesotans

July 7, 2015

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

RE: Project Number S5067025

Dear Ms. Acosta:

On May 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 14, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 7, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 14, 2015, effective June 23, 2015 and therefore remedies outlined in our letter to you dated May 28, 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.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 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 245067	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/7/2015
Name	of Facility		Street Address, City, State, Zip Code	
ST	LUCAS CARE CENTER		500 SOUTHEAST FIRST STREET	
			FARIBAULT, MN 55021	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item	(	Y5)	Date	(Y4)	Item	(	(Y5)	Date
ID Prefix	F0176		Correction Completed 06/23/2015		ID Prefix	F0225		Correction Completed 06/23/2015		ID Prefix	F0226		Correction Completed 06/23/2015
Reg. # LSC	483.10(n)		-		Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(	2) -	(4)		Reg. # LSC	483.13(c)		_ _
ID Prefix Reg. # LSC	483.15(a)		Correction Completed 06/23/2015		ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 06/23/2015			F0431 483.60(b), (d), (d		Correction Completed 06/23/2015
ID Prefix Reg. # LSC					ID Prefix Reg. # LSC			Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC					ID Prefix Reg. # LSC								Correction Completed
ID Prefix Reg. # LSC			-		ID Prefix Reg. # LSC								
Reviewed By		Reviewed I	Ву	Da	te:	Signature of Si	ırve	yor:				Date:	
State Agency	1	GL/mr	n	(	7/07/2	015	1	5507				07/0	7/2015
Reviewed By		Reviewed I	Ву	Da	te:	Signature of Si	urve	yor:				Date:	
Followup to Survey Completed on: 5/14/2015						-				a Summary of to the Facility?	YES	NO	

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245067	(Y2) Multiple Construction A. Building B. Wing 01 - MAII	N BUILDING 01	(Y3) Date of Revisit 6/24/2015
Name of Facility		Street Address, City, State, Zip Code	
ST LUCAS CARE CENTER		500 SOUTHEAST FIRST STREET FARIBAULT. MN 55021	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			06/23/2015		ID Prefix			06/23/2015		ID Prefix			06/23/2015
Reg. #	NFPA 101				Reg. #	NFPA 101				-	NFPA 101		_
LSC	K0017				LSC	K0045				LSC	K0070		_
									Τ.				
			Correction					Correction					Correction
ID Deefin			Completed		ID Deefer			Completed		ID Danfin			Completed
ID Prefix			06/23/2015		ID Prefix			=		ID PIEIIX			_
-	NFPA 101				Reg. #					Reg. #			_
LSC	K0144			<u> </u>	LSC				Щ.	LSC			_
			Correction					Correction					Correction
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Reg. # LSC					Reg. # LSC					Reg. # LSC			_
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			Correction					Correction					Correction
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LSC					LSC					LSC			<del>-</del>
				1-					+				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	<b>'</b>	Reviewed E	Зу	Da	ite:	Signature o	f Surve	yor:				Date:	
State Agency	y	PS/mn	n	C	7/07/20	15		25822				06/2	4/2015
Reviewed By	ı ——	Reviewed E	Зу	Da	ite:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of					1						
	5/12/	/2015					-				to the Facility?	YES	NO
				1									

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 7RBT

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY	AGENCY		Facility ID: 00571
1. MEDICARE/MEDICAID PROVIDER II (L1) 245067 2.STATE VENDOR OR MEDICAID NO. (L2) 470618800	NO.	3. NAME AND ADI (L3) ST LUCAS C (L4) 500 SOUTHE (L5) FARIBAULT	ARE CENTER EAST FIRST STI		(L6) <b>55021</b>		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	ON: 2 (L8)  2. Recertification  4. CHOW  6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 05/1-	7NERSHIP (L34)	7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual	PLIER CATEGOR 05 HHA 06 PRTF	Y 09 ESRD 10 NF	13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey Afte	9. Other er Complaint
8. ACCREDITATION STATUS:  0 Unaccredited	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	Œ	FISCAL YEAR END:	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	109 (L18) 109 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC	n		pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements  6. Scope of S 7. Medical D 8. Patient Ro 9. Beds/Room (L12)	Services Limit virector om Size
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  109  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILIT	Y MEETS ) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE  Sandra Tatro, HFE N	FII	Date :	06/16/2015		18. STATE S	SURVEY AGENCY API	seath	Date:
Canara Tatio, Fil E 14				(L19)	OFFICE O	OR SINGLE STAT	*	06/17/2015 (L20)
DETERMINATION OF ELIGIBILIT	Y	20. COM	PLIANCE WITH CITS ACT:			Statement of Financia	al Solvency (HCFA-2572) nterest Disclosure Stmt (F	
22. ORIGINAL DATE  OF PARTICIPATION  01/01/1967  (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEME ENDING DAT		VOLUNTAR 01-Merger, C 02-Dissatisfa	Closure action W/ Reimbursemen	05-Fail t	(L30)  UNTARY  to Meet Health/Safety  to Meet Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			voluntary Termination son for Withdrawal	OTHER 07-Prov 00-Activ	ider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C.	ARRIER NO.		30. REMAR	KS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION C	DF APPROVAL DA			d 06/17/2015 Co		
	(L32)			(L33)	DETERM	INATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

#### **REVISED**

June 2, 2015

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

RE: Project Number S5067025

Dear Ms. Acosta:

Please note: The date to achieve substantial compliance (May 23, 2015) noted on the original letter sent to you dated May 28, 2015 was in correct. The date the facility should achieve substantial compliance is June 23, 2015. See page 2 under, "OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES" where the changes to this letter were made.

On May 14, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<u>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:

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

#### 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 **June 23, 2015**, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by **June 23, 2015** the following remedy will be imposed:

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

#### PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of **the previous letter dated May 28, 2015**. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of **the previous letter dated May 28, 2015**, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 14, 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 November 14, 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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0310

May 28, 2015

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, Minnesota 55021

RE: Project Number S5067025

Dear Ms. Acosta:

On May 14, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<u>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:

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

#### 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 May 23, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 23, 2015 the following remedy will be imposed:

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

#### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 14, 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 November 14, 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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 05/28/2015 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY IPLETED
		245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER AS CARE CENTER			500	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTHEAST FIRST STREET RÍBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	) BE	(X5) COMPLETION DATE
F 000	as your allegation of Department's accept bottom of the first pube used as verificated.  Upon receipt of an a revisit of your facility that substantial com	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will	FC	000	RECEIVEI  JUN 15 2015  COMPLIANCE MONITORING DIV LICENSE AND CERTIFICATION	ISION	
	verification. 483.10(n) RESIDENDRUGS IF DEEME An individual reside the interdisciplinary	IT SELF-ADMINISTER D SAFE nt may self-administer drugs if	F 1	76	Resident (R151) was reassesse for ability to self-administer medications on 5-13-15 in accordance with facility policy and procedure. Resident was found to not be able to safely administer medications.		
	by: Based on observation review, the facility faself-administration of was completed for 1 received medication supervision of admir medication left at be Findings include: R151 was observed 8:18 a.m. A pill cup, glass of water were table. R151 explaine after eating breakfas	of 1 resident (R151) who from the nurse without nistration and/or had dside.  in her room on 5/12/15, at half full of medications and on the resident's bedside ed she took the medications at, and she was waiting for	September 1	y',	LPN – A received immediate re-education on 5/12/15.  Current residents, who wish to self-administer medications, will be re-assessed by the IDT on their ability to safely do so according to facility policy. Physician's orders to self-administer medications will be sought for those residents deemed safe to do so.  Licensed nursing staff will be educated on the facility SAM policy and procedures and the Self Medication Assessment process by 6-23-15.	50	
ABORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER BEPRESENTATIVE'S SIGNA	ATURE	-	Administrator	60-	(6) 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.

Facility ID: 00571

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		ATE SURVEY DMPLETED
			245067	B. WING	i		0	5/14/2015
		PROVIDER OR SUPPLIER		<b>L</b>	5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
PR	4) ID EFIX AG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F		what kind of pills are morning."  R151 was newly ad and did not have Mithe time of the obse medical record identiculde memory loss (loss of vision).  R151's unsigned phydid not direct the state the bedside. Orders (dietary supplement) capsules daily, furos fluid from the tissues 30 mg daily, Lisinope 40 mg daily, calcium 1 tablet twice daily, constipation) 100 mg (for iron deficiency at metoprolol tartrate (follood pressure) 50 mg abapentin (for seizulimes daily. All medical medication administered at 8:00 R151's medical record determine whether the self-administer medical or R151 dated 5/6/18 ability to self-administer.	we. R151 stated, "I don't know a these, but I take pills every mitted to the facility on 5/6/15, nimum Data Set completed at rvation. The electronic tified R151's diagnoses to and unspecified glaucoma sysician's orders dated 5/6/15, ff to leave the medications at included: fish oil capsule 1000 mg (milligrams) 2 emide (to remove excess 1) 40 mg daily, lansoprazole will (to lower blood pressure) rum chloride extended release ency) 20 mili-equivalent revitamin D 500-200 mg-unit relocusate sodium (for twice daily, ferrous sulfate themia) 325 mg twice daily, for chest pain or to lower rug by mouth twice daily, and rug disorder) 300 mg three cations were scheduled in histration record to be a.m.  and lacked an assessment to e resident could safely sation (SAM). The care plan 5, did not address R151's	F1	176	Facility SAM policy and procedure was reviewed and remains current.  Weekly random audits will be conducted on each nursing unfor a period of at least 90 days to ensure residents and staff remain complaint with self-administration of medication orders and facility policy.  Audits will be reviewed by the Director of Nursing and/or Designee and submitted to the monthly Quality Assurance committee for input and recommendations on the need for continued monitoring  The facility QAPI committee will review the status of resident self-administration audits monthly for further recommendations.  The Director of Nursing or designee will be responsible for the ongoing compliance.	it '	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		PLETED
		245067	B. WING			05/	14/2015
	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	) BE	(X5) COMPLETION DATE
F 176	been completed for R151's room, took bedside table and repractical nurse (LP)  On 5/12/15, at 8:25 not supposed to haw without confirming place. LPN-A explainmedications after bethe bedside table.  The DON then connot have a SAM as stated she expected ensure residents we facility's policy.  The facility's 8/13, Medications policy admission, nursing would like to self-administer, the assess the resident has expreself-administer, the assess the resident visual ability to carrectly facility may require the nurse until the opportunity to obtain make an assessment completed within self-administer me resident's care plated 483.13(c)(1)(ii)-(iii)	R151. The DON then entered the cup of pills from R151's returned it to the licensed N)-A.  6 a.m. LPN-A stated she was we left medications with R151 she had a SAM assessment in ined R151 wanted to take her reakfast, so they were left on firmed at 8:26 a.m. R151 did resessment completed and desessment completed and desessment reaking medications per the Self-Administration of directed staff to: "Upon will ask each resident if they dminister medications. If the seed a desire to a interdisciplinary team will t's cognitive, physical and reproduction of the administered by care planning team has the in information necessary to that drugs be administered by care planning team has the in information necessary to the entire or until the care plan is even days upon completion of assessmentNursing to get only sician for self-administration cumentation of the ability to dications will appear on the n."  (c)(2) - (4)		2225			
SS=D		PORT					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
	<b>,</b>	245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER			500	EET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST FIRST STREET RIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH 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 APPROPS DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatminiculating injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must have a violations are thoroup revent further pote investigation is in proposition of the administrator representative and the with State law (includent, and if the administrator incident, and if the administration is in proposition of the administrator representative and the state law (includent, and if the administration is in proposition).	t employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies.  sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the ertification agency).  ve evidence that all alleged ughly investigated, and must intial abuse while the rogress.	F 2	25	The injury of unknown origin for R39 was reported to the Administrator and the State survey and certification agency on 4-15-15. Investigation was completed and the investigative report was submitted to the State agency on 4-21-15. On 4-22-15 the facility received disposition letter from the State Agency stating that the information had been review and it had been determined that no further action was necessary at that time.  All alleged occurrences of injuries of unknown origin will be thoroughly investigated by the Director of Nursing and /or designee in accordance with facility policy.  Prior to the completion of the investigation, the investigative report will be reviewed with the Administrator and/or designee to ensure the investigation is through and complete including: relevant dates and times, summary of all investigative interviews with al staff involved in the incident, identification of alleged staff member, identification of the resident, and interventions implemented to prevent a recurrence of the incident.	d d	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:7RBT11		Facility	ID: 00571 If continuat	ion sheet	Page 4 of 22

	TATEMENT OF BETTOLES		` '	TIPLE CONST		(X3) DATE SURVEY COMPLETED	
		245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER AS CARE CENTER			500 SOUT	DDRESS, CITY, STATE, ZIP CODE THEAST FIRST STREET ULT, MN 55021		
(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 ROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	This REQUIREMENt by: Based on observatoreview the facility fainvestigation to rule for 1 of 1 resident (I of unknown origin.) Findings include: R39 was observed p.m. The resident hattempt to interview unsuccessful.  On 5/11/15, at 2:41 (RN)-B explained thankle that occurred 4/14/15." Although for 4/14/15, she had following day that R the bed during a tranot, however, know incident, such as when exactly the retransfer to/from toile 3/11/15, an addition that read, "assist of falls."  R39's quarterly Mini 3/6/15, revealed dia and stroke. R39 was required extensive as a significant of the significan	NT is not met as evidenced ion, interview and document illed to complete an thorough out potential neglect of care R39) who sustained a fracture lying in bed on 5/11/15, at 2:00 ad a cast on her right foot. An	F 2	Find the second of the second	The facility vulnerable adult abuse prohibition policy and procedure has been reviewed and remains current.  Facility staff responsible for incident investigation have been educated on the facility policy and procedure for thorough investigation in accordance with facility vulnerable adult abuse prohibition policy.  The facility QAPI committee will review the status of investigation reporting of injuries of unknown cause monthly for further ecommendations.  Ongoing monitoring to ensure compliance will be conducted by the Administrator or lesignee through investigation eport review to assure investigations are thorough and occurate.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		G		MPLETED
		245067	B. WING	i		05	/14/2015
	PROVIDER OR SUPPLIER AS CARE CENTER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	on and off the unit,  A progress note dat "Licensed practical from the trained me they noted resident leg gave in as she s swollen. Assessed around to right ankl to touch. When ask resident stated, 'It g [TMA-A]. The reside wrong, it hurts.' The what that statement unable to recall. The notified via noteboo at appropriate time  The facility's interna who were interviewe cared for the reside how the injury occu the resident was inj investigative intervie The interviews lack approximate times to R39. In addition, no had provided cares the resident to bed were as follows:  1) NA-C reported, "S bathroom, but didn's and was able to bea transfer to bed."  2) NA-D's interview shower on 4/14/15,	dressing and toileting.  ted 4/15/15, at 6:37 a.m. read, nurse [LPN-C] was informed edication assistant [TMA-A], had difficulty standing; right stood. Right ankle was right ankle, swelling noted all e. No bruising noted. Tender ed resident what happened, to caught under the bed' per ent stated, 'She put it on e nurse [LPN-C] asked her to meant and the resident was e director of nursing [DON] ak. Family will be called today due to no serious injury."  al investigation revealed staffed reported they had either not nt, had no knowledge as to rred, and/or had not noticed	F2	225			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURV COMPLETE		
		245067	B. WING			05/	14/2015	
	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTIES OF THE A	D BE	(X5) COMPLETION DATE	
F 225	Continued From pa	age 6	F	225				
	bear weight and he	interview read, "[R39] couldn't e noted her right ankle was the [TMA-A] know."						
	4) TMA-A's intervien nurse and the nurse	ew showed, "She informed the se elevated the leg."						
	DON reported she reported her foot v DON stated R39 v 9:05 a.m. the DON RN-B reiterated th working at the time to her that R39 stashe got "her 'foot of the DON reported cared for the residuand was unaware sheets directed stand was when as for R39. When as it is not be to the pool of the pool of the pool of the residuand was unaware sheets directed stand was when as it is not be the pool of the pool	w on 5/13/15, at 9:00 a.m. the was unaware R39 had was caught in the bed. The was known to self-transfer. At and RN-B were interviewed, at although she was not e of R39's injury, it was reported ated at the time of the incident caught' in the bed." At 9:25 a.m. she did not know who had lent at the time of the incident, the care plan and the NA care aff to use a two person transfer ked if one person had sident the DON replied, "Yes."						
	incident report sul agency (SA) which transferred and [N difficulty standing noted that area whom 4/15/15, area X-ray resulted in malleolus inferior transfersStaff hassessment was shift around 1930 does self transfer hallway to meals	5 a.m. the DON reviewed the omitted to the designated State in read, "On 4/14/15, [R39] was IA-A] noted that resident had and right leg gave out. [LPN-C] as swollen and not bruise [sic]. assessed again and x-ray [sic]. non-displaced fracture lateral y. [R39] stated it was twisted on ad given her a shower and skin done but on 4/14/15 evening [7:30 p.m.] it was noted. [R39] s and self propels down the and activities. It is also possible we hit ankle against something					act Page 7 of 2	

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					
STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	plan of care by care communication boomedical record."  On 5/13/15, at 2:25 worked with R39 the NA-C reported she	age 7 .Staff are made aware of the eplan, care data sheets, the ok, nursing report, and the p.m. NA-C verified she had be evening shift on 4/14/15. had "only" walked into R39's up in her chair and check for	Fí	225			
	incontinence, and the down. She denied bathroom and again up" and checked had had an	transferring the resident to the stated she "just stood her er prior to the evening meal. who took escorted R39 to the o had assisted the resident to evening shift. NA-C was shown her as the person responsible he evening shift of 4/14/15. everyone helps" and again the head assisted her aring the evening shift on two staff persons were er the resident, but said "some her esident with only one at R39 was not exhibiting any at the time she worked with ow how the injury occurred. By have assisted R39 the were unavailable for an					
	indicated staff wou minimized by "The number of staff on of the residents, ar has knowledge of i	A, Abuse Prevention Plan Id ensure neglect was assignment of a sufficient each shift to meet the needs and assure the staff assigned ndividual care needs." In read, "Facility will investigate					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245067	B. WING		05/14/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
SS=D	all incidences of fall resident complaints staff member respo event and implemer keep the resident sa up/implementation the appropriate for resident." Under intedirected staff to conforce of the resident, speathe situation and do documentation will infood the resident, Iden as the time, date, loany other information situation. Staff were to determine what copolicy and procedur occurrences." Signs investigation include noted "Each and ever internal investigation intervention at the time planned to attempt to the repeat incident."  483.13(c) DEVELOF ABUSE/NEGLECT,  The facility must developlicies and proceduristreatment, neglecand misappropriation	s, bruising, medication error, etcThe facility identify the ensible forinvestigation of the ents immediate changes to afe; with follow o make sure they are dent and condition of ernal reporting the policy duct a physical assessment aking to all staff involved in cument such findingsThe include the following: Identity tity of the caregiver," as well cation, nature and extent, and in helpful in investigating the exto then"Analyze occurrences hanges are needed if any in esto prevent further of potential neglect requiring and fractures. The policy also ery incident will have an inAll incidents will have an ine of the incident and care or reduce the chances of a PIMPLMENT ETC POLICIES	F 22	The facility vulnerable adult abuse prohibition policy and procedure has been reviewed and remains current.  Facility staff responsible for incident investigation have been educated on the facility policy and procedure for thorough investigation in accordance with facility vulnerable adult	n
	Based on observation	on, interview, and document		abuse prohibition policy.	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY		
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		DING	COMPLETED		
		245067	B. WING		05/14/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR GOLF ELER			500 SOUTHEAST FIRST STREET			
ST LUCA	S CARE CENTER			FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EVCH DEEICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE   COMPLETION		
F 226	Continued From pareview, the facility of conducting a thoromeglect of care for sustained a fracture.  Findings include:  The facility's 1/3/14 indicated staff wou minimized by "The number of staff on of the residents, and has knowledge of it addition, the policy all incidences of faresident complaint staff member respected to a many of the resident sup/implementation appropriate for respected staff to confide the resident, spot the situation and documentation will of the resident, any other informat situation. Staff we to determine what policy and procedure occurrences." Signinvestigation inclured "Each and einternal investigation at the intervention at the conduction of the resident intervention at the conduction of the	rage 9 Failed to follow their policy for ugh investigation into potential 1 of 1 resident (R39) who e of unknown origin.  If, Abuse Prevention Plan Id ensure neglect was assignment of a sufficient each shift to meet the needs and assure the staff assigned individual care needs." In read, "Facility will investigate Ils, bruising, medication error, s, etcThe facility identify the consible forinvestigation of the ents immediate changes to	F	All alleged occurrences of injuries of unknown origin wi be thoroughly investigated by the Director of Nursing and /o designee in accordance with facility policy. Prior to the completion of the investigation the investigative report will be reviewed with the Administrator and/or designee to ensure the investigation is through and complete including: relevant dates and times, summary of investigative interviews with staff involved in the incident, identification of alleged staff member, identification of the resident, and interventions implemented to prevent a recurrence of the incident.  Investigative summaries of incidents of injuries of unknown origin will be reviewed by the QAPI committee monthly for IDT input and recommendations.  Ongoing monitoring to ensur compliance will be conducted by the Administrator and/or designee through investigation report review to assure investigations are thorough a accurate.  Date of completion: 6-23-15	all all on and		

	TEMENT OF DEFICIENCIES  D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	COMPLETED		
		245067	B. WING			05/ <sup>-</sup>	14/2015	
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	p.m. The resident h 5/11/15, at 2:41 p.m explained the residoccurred on the ever Although RN-B did 4/14/15, she had reday that R39 got he during a transfer. R however, know any such as what staff the resident sustain. The care plan for R "The resident is to living a transfer to/from toil 3/11/15, an addition that read, "assist of falls."  R39's quarterly Min 3/6/15, revealed dia and stroke. R39 warequired extensive daily living (ADLs) son and off the unit,  A progress note da "Licensed practical from the trained methey noted resident leg gave in as she is the stroke of the unit, and the unit of the unit, and the stroke of the unit, and the stroke of the unit, and the unit of the unit, and the unit of	lying in bed on 5/11/15, at 2:00 had a cast on her right foot. At n. a registered nurse (RN)-B ent had "a fractured ankle that ening shift on 4/14/15." not work the evening of exceived a report the following er foot caught under the bed en. Breported she did not, a specific details of the incident, were involved or when exactly ned the injury.  139 revised 12/15/14, indicated have assistance of two staffed transfers, needs two staffed transfers, needs two staffed transfers to prevent on was made to the care plan for transfers to prevent of a cognitively impaired and assistance for activities of such as transfers, locomotion dressing and toileting.  150 ted 4/15/15, at 6:37 a.m. read, nurse [LPN-C] was informed edication assistant [TMA-A], thad difficulty standing; right stood. Right ankle was	F 2	226	· ·			
	around to right ank to touch. When ask resident stated, 'It g	right ankle, swelling noted all le. No bruising noted. Tender ked resident what happened, got caught under the bed' per ent stated, 'She put it on			·			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		: CONSTRUCTION	COMPLETED		
		245067	B. WING	-		05/	14/2015	
	PROVIDER OR SUPPLIER			50	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTHEAST FIRST STREET ARIBAULT, MN 55021	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 226	wrong, it hurts.' The what that statemen unable to recall. The notified via notebood at appropriate time. The facility's internative was appropriate time. The facility's internative was in investigative interview cared for the resident was in investigative interviews lack approximate times R39. In addition, not had provided cares the resident to bed were as follows:  1) NA-C reported, 'bathroom, but didn and was able to be transfer to bed."  2) NA-D's interviews shower on 4/14/15, swollen and the resident weight and he swollen and he let the swollen and the nurse and the nurse During an interview DON reported she reported her foot we reported her foot weight and her foot weight and her foot weight and her foot weight and the nurse and the nurse foot weight and her foot weight and her foot weight and her foot weight and her foot weight and the foot weight	e nurse [LPN-C] asked her t meant and the resident was e director of nursing [DON] ok. Family will be called today due to no serious injury."  al investigation revealed staff red reported they had either not ent, had no knowledge as to urred, and/or had not noticed jured. The facility's ews were all dated 4/15/15. Red information as to even the various staff cared for one of the staff verified who is such as to ileting and assisting on 4/14/15. The interviews  The took the resident to the it see any swelling to ankle ar weight. States she didn't indicated, "She gave [R39] a and the right ankle was not sident did not have pain."  Interview read, "[R39] couldn't interview read, "[R39] couldn't interview read, "[R39] couldn't interview read, "She informed the showed, "She informed the		226				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		245067	B. WING				/14/2015
	PROVIDER OR SUPPLIER			500	EET ADDRESS, CITY, STATE, ZIP CO SOUTHEAST FIRST STREET RIBAULT, MN 55021		
(X4) ID PREFIX TAG	/EACH DEELCIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION COROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	9:05 a.m. the DON RN-B reiterated th working at the time to her that R39 stashe got "her 'foot of the DON reported cared for the resid and was unaware sheets directed st for R39. When as transferred the residancy (SA) which transferred and [N difficulty standing noted that area won 4/15/15, area X-ray resulted in malleolus inferior transfersStaff hassessment was shift around 1930 does self transfer hallway to meals that she could have causing the bread plan of care by communication by medical record."  On 5/13/15, at 2: worked with R39 NA-C reported signom to stand he incontinence, and the death of the plan of care by communication by medical record."	age 12 I and RN-B were interviewed. at although she was not of R39's injury, it was reported ated at the time of the incident caught' in the bed." At 9:25 a.m. she did not know who had ent at the time of the incident, the care plan and the NA care aff to use a two person transfer ked if one person had sident the DON reviewed the mitted to the designated State in read, "On 4/14/15, [R39] was IA-A] noted that resident had and right leg gave out. [LPN-C] as swollen and not bruise [sic]. assessed again and x-ray [sic]. non-displaced fracture lateral y. [R39] stated it was twisted or ad given her a shower and skin done but on 4/14/15 evening [7:30 p.m.] it was noted. [R39] and self propels down the and activities. It is also possible we hit ankle against something k Staff are made aware of the are plan, care data sheets, the ook, nursing report, and the		226		f continuation sh	eet Page 13 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245067	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	05/	14/2015
NAME OF PROVIDER OR SUPP				5 5			
(EACH DEFIC	IENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
NA-C did not ke dining room, ouse the toilet to a sheet identiff for caring for FNA-C respond denied that alto responsible for with transferring 4/14/15. NA-C supposed to the staff' transferring person. NA-C supposed to the staff' transferring of ankle her, nor did should be derived.  F 241 SS=D INDIVIDUALITY  The facility must manner and in enhances each full recognition.  This REQUIR by: Based on obstreview, the fact assistance for assistance for a specific process.	ed he now how who we have ed he now how he en out of the en out of he en out o	ge 13 er prior to the evening meal. who took escorted R39 to the had assisted the resident to vening shift. NA-C was shown her as the person responsible he evening shift of 4/14/15. Everyone helps" and again he she was listed as primarily of that she had assisted her ring the evening shift on two staff persons were er the resident, but said "some er resident with only one d R39 was not exhibiting any at the time she worked with ow how the injury occurred. If y have assisted R39 the were unavailable for an an environment that maintains or ident's dignity and respect in its or her individuality.  Note that the evening shift on two staff persons were er the resident with only one draw as a single for an an environment that maintains or ident's dignity and respect in its or her individuality.  Note that the evening meal.  Table to the exception of the evening shift on the evening shift of 4/14/15.  Table the evening shift on the evening shif	F 2	226	NA-A, RN-A, and RN-C were re-educated on the Resident Dining Room and Quality of Life-Dignity policies.  Interviews with other residents have been conducted to determine if they were affected by the actions of NA-A, RN-A or RN-C. Residents involved had no recollection or adverse reaction to the incident.  The policies titled Resident Dining Room and Quality of Life-Dignity were reviewed and remain current.  Nursing staff will be reeducated on the policies by 6-23-15.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021	NA .	(X5)
(X4) ID PREFIX TAG	ALVOIT DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRE	COMPLETION DATE
F 241	5/11/15, from 6:00 R12, R18, R96, an same table. A nurs registered nurse (Fresidents with their feeding the resident NA-A fed R96 and R12. R12 intermit and fluids through their back to the first second, and then second while assist At the end of the rist NA-A both explain on the unit, but we and NA-A each stabetween two resident.  NA-B was intervied NA-B sat while feed encouraging anoth normally staff sat assisting with eating were "new."  The following day and R103 were as and were assisted stood while period bites of food. Addreturned several such as obtaining explained it was ever residents to ensurroom during the residents to ensurroom duri	service was observed on to 6:41 p.m. Four residents, and R103 were seated at the sing assistant (NA)-A and a RN)-A each assisted two remeal. Both staff stood while not shroughout the entire meal. R18, and RN-A fed R103 and tently coughed/choked on food out the meal. Both staff turned rest resident while assisting the turned their back toward the sting the first, and so on.  In eal at 6:41 p.m. RN-A and ed they did not normally work are "filling in" that shift. RN-A ated they normally stood dents while assisting them to even on 5/11/15, at 6:50 p.m. eding one resident and her resident to eat. NA-B stated beside a resident while and, however, RN-A and NA-A at 8:36 a.m. R12, R18, R96, gain seated at a table together d to eat their breakfast. RN-C dically assisting residents with ditionally, RN-C left the table and times to complete other tasks a juice for a resident, etc. RN-C easier for her to monitor the re they did not leave the dining meal if she stood while assisting meal if she stood while assisting	d	241	Random weekly audits will be conducted in each dining room for 90 days to ensure staff are assisting residents in a manner which enhances or maintains each resident's dignity in accordance with facility policy.  Audits will be reviewed by the Director of Nursing and/or designee and submitted to the monthly Quality Assurance committee for input and recommendations on the need for continued monitoring.  The Director of Nursing and/or designee will be responsible for the ongoing monitoring for compliance.  Date of completion: 6-23-15	or r	
	them to eat.	Event ID: 7RR		-	Facility ID: 00571 If continu	uation shee	t Page 15 of 22

	CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MUL	TIPLE		(X3) DATE SURVEY COMPLETED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	PLETED
AND FLAN O	OOMALOWAN		D VARNIC			05/	14/2015
		245067	B. WING	ST	REET ADDRESS, CITY, STATE, Z		
NAME OF P	ROVIDER OR SUPPLIER				0 SOUTHEAST FIRST STREE		
ST LUCA	S CARE CENTER			F.A	ARIBAULT, MN 55021		
(X4) ID	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	6	DEFICIENCE DEFICIENCE	CY)	
F 241	Continued From page	age 15	F	241			
	Following breakfas	st at 8:50 a.m. R103 was asked					
	about breakfast, h answer any questi	owever, he was unable to					
	R12's care plan da	ated 2/8/13, revealed, I have					
	abowing difficulty	secondary to advanced					
	I related to 1 wt loss	inadequate oral intake r/t s, fair appetite, AEB [as					
	avidenced by sign	nificant weight loss x 1, 3, and o					
	months and variab	ole intake at mealsI have ually lost weight d/t					
	comorbidities (dis	ease process) despite nutrition					
	lintaryantions "Inte	erventions included assisting rinking as necessary, as well as		•			
	monitoring for sign	ns and symptoms of chewing,					
	cwallowing or po	cketing of food. R12 was to be					
	offered a regular	pureed diet with nectar thick ween meal supplementation.					
	R18's care plan d	lated 11/14/14, showed, "I am at dehydration r/t dependence on					
	-toff for fooding/c	Irinking and Inickened Ilquids					
	diet order "Interv	entions directed stail to one					
	additional fluids,	and to monitor for signs and iration (inhalation of food or					
	fluids causing pn	eumonia).					
	Boele care plan (	dated 11/2/14, noted "I was ofter	1				
	refucing maals W	high caused weight loss so i	1				
	receive coveral s	supplements per day to help the	et   s				
	r/t disease progre	s. I had unavoidable weight los ession. I am not allowing staff to	5				
	l assist me during	mealtime and am eating the					
	majority of meals	s" The goals included ht and interventions included					
	staffs' assistance	e at mealtime.					
		n dated 5/2/14, noted, "I have					
	R103's care plar	Tualed 5/2/14, Hoted, That's	T11	F	Facility ID: 00571	If continuation she	et Page 16 of 2

PRINTED: 05/28/2015 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				·	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245067	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 282 SS=D	recordsI feed mys staff cues and encornever been a big ear encouraging intake. The director of nurs 5/13/15, at 10:46 a. expectation staff saresidents while assistant was "unacceresident while assistant	ske r/t dementia ABE intake self with set-up assist, but the surages me to eat. I have ater." Interventions included at meals.  sing (DON) was interviewed on m. The DON stated it was her t and had conversation with sting them to eat. The DON ptable" to stand over a ting them to eat. On 5/14/15, N explained R103 periodically to eat.  Resident's Dining Room policy ovide residents with a here at mealtimes." A 1/14, hity policy noted, "Each red for in a manner that noces quality of life, dignity, uality."  RVICES BY QUALIFIED		2241	NA-C received immediate reeducation regarding following all residents individualized plan of care.  The policy and procedure for care planning was reviewed and remains current.  Nursing staff will be reeducated by 6-23-15 on following each resident's individualized plan of care.	:	
	Findings include.						

Event ID:7RBT11

PRINTED: 05/28/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		PLETED
		245067	B. WING			05/	14/2015
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	5 F	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
F 282	R39's care plan revas follows: "The restwo staff with ambut two staff to transfer requests." On 3/11 the care plan that represent falls."  R39 was observed p.m. The resident falls."  A progress of the evertical falls of the resident falls of the specific details of the specific details of the wastained the injury.  A progress note da "Licensed practical from the trained methey noted resident leg gave in as she swollen. Assessed around to right ank to touch. When ast resident stated, "It [TMA-A]. The resident stated, "It [TMA-A]. The resident statement unable to recall."	rised 12/15/14, directed staff sident is to have assistance of plation and transfers, needs to/from toilet as she /15, an addition was made to ead, "assist of 2 for transfers lying in bed on 5/11/15, at 2:00 had a cast on her right foot. At red nurse (RN)-B explained fractured ankle that occurred to n4/14/15." Although RN-B ening of 4/14/15, she had he following day that R39 got der the bed during a transfer. did not, however, know any the incident, such as what staff hen exactly the resident		282		e	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	COMPLETED	
		245067	B. WING		05/	14/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ( (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	working at the time to her that R39 states she got "her 'foot cate the DON reported so cared for the reside and was unaware to sheets directed states for R39. When asked transferred the residence of the residence of R39. When asked transferred the residence on the R39. When asked transferred the r	t although she was not of R39's injury, it was reported ed at the time of the incident aught' in the bed." At 9:25 a.m. she did not know who had ent at the time of the incident, he care plan and the NA care ff to use a two person transfer ed if one person had dent the DON replied, "Yes."  p.m. NA-C said two staff osed to transfer the resident, f' transferred the resident with ens was requested and not DRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an cion; and determines that drug r and that an account of all maintained and periodically eals used in the facility must be not evited and include the	F 2		- ;	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245067	B. WING			0.5	5/14/2015
	PROVIDER OR SUPPLIER  AS CARE CENTER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	locked compartmen controls, and permit have access to the The facility must propermanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distributed quantity stored is mit be readily detected.  This REQUIREMEN by: Based on observation on the transitional candition, the facility fair was not stored for use on the transitional candition, the facility fair stocked medications the north-south cart (LTC), potentially affect those units.  Findings include:  The facility's medicate observed on the TCU at 1:00 p.m. R16's Nat room temperature date; the last refill date medication storage ocarts on the TCU and carts on the TCU and carts.	ts under proper temperature only authorized personnel to	F4	31	Random weekly audits will be conducted for 90 days on each nursing unit to ensure medications are stored proper according to facility policy are procedure.  Audits will be reviewed by the Director of Nursing and/or designee and submitted to the monthly QAPI Committee for input and recommendations of the need for continued monitoring.  The Director of Nursing and/or designee will be responsible for the ongoing monitoring for compliance.  Date of completion: 6-23-15	ly dd e	

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245067	B. WING	<u> </u>		05/	14/2015
	PROVIDER OR SUPPLIER  AS CARE CENTER			STREET ADDRESS, CITY, STATE, Z 500 SOUTHEAST FIRST STREE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPR	BE	(X5) COMPLETION DATE
	inflammation) 325 r opened date of 1/20 11/20/14, and the so of 4/15; 2) folic acid (to produce a.m. and 10 units date of 2/26 11/20	pirin (for pain, fever, milligrams (mg) one with an 0/15, and expiration date of econd with an expiration date duce and maintain new cells) ned date of 6/1/14, and 1/15; revent urinary tract infections) and date of 12/16/14, and 1/14; artburn/indigestion) with an 15, and expiration date of expiration date of with an opened date of 3/6/15, of 3/15; and expiration date of examplement) with an 1/14, and expiration date of examplement) with an 1/14, and expiration date of examplement) with an 1/14, and expiration date of examplement of examplem	F	431			

	ND PLAN OF CORRECTION I IDENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245067	B. WING			05	5/14/2015
	PROVIDER OR SUPPLIER  AS CARE CENTER			STREET ADDRESS, CI 500 SOUTHEAST FII FARIBAULT, MN &	RST STREET		, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULE RENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	director of nursing (lacked an opened directions were in explained that staff expiration dates, datexpiration dates, refrom the medication the storage room for that Novolog mix 70 once opened.  A registered nurse (on 5/11/15, at approhouse stock medicates shown to her had exthe expired medication the facility's 7/13, Mindicated "no discondeteriorated medication deteriorated medication facility. All such The manufacturer's mix 70/30 noted insu	on 5/11/15, at 1:29 p.m. the DON) verified R16's insulin ate and the stocked house ideed expired. The DON was to check medications for te insulins with opened and move any expired medications carts, and place the items in r destruction. The DON stated is was viable for 28 days  RN)-B verified in an interview ximately 1:45 p.m. that the tion on the north-south cart cpired. RN-B explained that ions should have been redications: Storage of policy	F 4	31			

F5067023

PRINTED: 05/28/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 245067 B WING 05/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 SOUTHEAST FIRST STREET** ST LUCAS CARE CENTER FARIBAULT, MN 55021 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | INITIAL COMMENTS POCK 15-15 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St Lucas Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC). Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES 1 0 2015 (K-TAGS) TO: MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

CENTER	13 FOR MEDIOANE	A MEDIO/AD CENTION		_			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245067	B. WING			05/	12/2015
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTHEAST FIRST STREET ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of volto correct the deficition.  2. The actual, or proposed in the second of th	tate.mn.us and n@state.mn.us  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  If title of the person rection and monitoring to ence of the deficiency.  Center was constructed at 5 are original building is a 4-story sement. It was constructed in rmined to be of Type I (332) st and 2nd floor are used for 30 a 1-story addition was as determined to be of Type II with no basement. In 1971 a seconstructed and was for Type II (111) construction, at. In 1990 a 1-story addition and was determined to be of uction, with no basement. In as constructed and was for Type II (111) construction, and was determined to be of uction, with no basement. In as constructed and was for Type II (111) construction, the second the original building and meet the construction isting buildings, the facility was	K	000			
	The building is fully	sprinklered. The facility has a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245067	B. WING	_		05/	12/2015
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	fire alarm system w detection and space monitored for auton notification.  The facility has a ca census of 68 at the  The requirement at	ith full corridor smoke es open to the corridors that is natic fire department espacity of 109 beds and had a time of the survey.  42 CFR, Subpart 483.70(a) is	K	000			
K 017 SS=F	Corridors are separ constructed with at rating. In sprinklere required to resist th non-sprinklered bui above the ceiling. (at the underside of permitted by Code. waiting areas, dinin may be open to the conditions specified be separated from the constructions.)	rated from use areas by walls least ½ hour fire resistance ed buildings, partitions are only e passage of smoke. In Idings, walls properly extend Corridor walls may terminate ceilings where specifically Charting and clerical stations, g rooms, and activity spaces corridor under certain I in the Code. Gift shops may corridors by non-fire rated is fully sprinklered.)	K	017			
	This Standard is no	s not met as evidenced by: ot met as evidence by: on and staff interview, the					
		, , , , , , , , , , , , , , , , , , , ,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURV COMPLETED		
		245067	B. WING _	9	05/12/201	15
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	(5) LETION TE
K 017	facility failed to provaccordance with the 101, Sections 19.3. 19.3.6.2.2. The de out of 68 residents.  Findings include:  On facility tour betwon 05/12/2015, obseaddition that there a ceiling around beam The building is fully open grate ceiling tiltransfer of smoke.  This deficient practic Facility Maintenance	ge 3 ride corridor wall separation in a requirements of 2000 NFPA 5, 19.3.6.1, 19.3.6.2.1 and ficient practice could affect 30  een 9:15 AM and 12:30 PM ervation revealed in the 1990 re penetrations above the as, sprinkler lines and cabling, sprinkled, however, there are les that do not limit the ee Director (DM) at the time of	K 01	The roof top unit for the 1990 building addition will have ducted returns installed and to open grate ceiling tiles will be removed and replaced with solid ceiling tiles.  Ongoing compliance will be monitored by the Director of Environmental Services and/designee  Date of Completion: 6-23-1.	ne e	
K 045 SS=D	Illumination of mean discharge, is arrang lighting fixture (bulb) darkness. (This doe lighting in accordance)  This STANDARD is Based on observatifacility failed to provi components of the nuby 2000 NFPA 101, 3	s of egress, including exited so that failure of any single will not leave the area in es not refer to emergency se with section 7.8.) 19.2.8  not met as evidenced by: on and staff interview, the de reliable lighting for all neans of egress as required Section 192.9.1, 7.8, and ractice could affect 20 out of	K 048	The lower level SW exit has had a 2-bulb fixture installed.  All other exits have been inspected and additional lighting is being installed to assure all exits are compliant.  Ongoing compliance will be monitored by the Director of Environmental Services and/or designee  Date of Completion: 6-23-15		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245067	B. WING	_		05/12/2015	
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE	(X5) COMPLETION DATE
K 045	Continued From pa	ge 4	Κú	)45			
K 070 SS=D	on 05/12/2015, obsorborned on 05/12/2015, obsorb	nd employee areas where the such devices do not exceed degrees C) 19.7.8	KO	070	Facility policy regarding devices has been developed stating that portable space heating devices are permitted only in non-sleeping staff and employee areas. Portable heating devices elements must not exceed 212 degrees F.  The Maintenance Director and/or designee will conduct random monthly audits for 90 days to assure compliance with established portable space heating device policy.  Ongoing compliance will be monitored by the Director of Environmental Services and/or designee  Date of Completion: 6-23-15	h	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245067	B. WING	_		05/12/2015	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 070	Lower Level - office heater not plugged in, but the facility did addressing where in may be used or how evaluated to assure requirements of NF 19.7.8.  This deficient practification of the facility Maintenance discovery.  NFPA 101 LIFE SAI Generators are inspunder load for 30 m accordance with NF accordance with NF accordance with NF assed on document interview, the facility emergency generator requirements of 200	ervation revealed that the area, had 1 portable space in and 1 was that was plugged do not have written policies in the facility the space heater with the space heater was a that they meet the PA 101-2000 edition, Section ce was confirmed by the e Director (DM) at the time of FETY CODE STANDARD pected weekly and exercised inutes per month in FPA 99. 3.4.4.1.	K 1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245067	B. WING			05/12/2015	
	PROVIDER OR SUPPLIER  AS CARE CENTER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)		) BE	(X5) COMPLETION DATE
K 144	On facility tour betwon 05/12/2015, door emergency generat 1. Transfer time was 2. The Facility Main confirmed that the fathe reliable fuel sour emergency generate all five points as required as A statement of renatural gas delivery b. A brief description regarding the reliable c. A statement that interruption of the natural gas vendor. 3. The signature of natural gas vendor. 3. The 2 hour load be 30 minutes - 25%, nlast 1 hour - 75%)	reen 9:15 AM and 12:30 PM umentation review of the or revealed the following:  Is not recorded tenance Director (DM) acility did not have a letter for ree for the natural gas or. The letter needs to contain uired below:  It is a low probability of the or that supports the statement lity there is a low probability of atural gas or that supports the statement obability of interruption technical personnel from the lank test was not run at (first ext 30 minutes - 50%, and only the extraction of the lank test was not run at the ext and minutes of the lank test was not run at (first ext 30 minutes - 50%, and only the extraction of the lank test was not run at (first ext 30 minutes - 50%).	K 1	144	Proper recording of emergency generator transfer time has been reviewed with the service tech.  Transfer times a now documented on the monthly load test inspections.  Facility has received a letter from Xcel Energy which includes a statement of reasonable reliability of the natural gas delivery, a description that supports the reliability statement, a statement that there is a low probability of interruption of the natural gas, a statement of low probability of interruption and the signature of technical personnel from Xcel.  The two-hour load bank test at 25% load for 30 minutes, 50% load for the next 30 minutes, and 75% for the last hour was completed on 5-18-15.  Ongoing compliance will be monitored by the Director of Environmental Services and/or designee.  Date of Completion: 6-23-15		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0310

May 28, 2015

Ms. Jill Acosta, Administrator St Lucas Care Center 500 Southeast First Street Faribault, MN 55021

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5067025

Dear Ms. Acosta:

The above facility was surveyed on May 11, 2015 through May 14, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

St Lucas Care Center May 28, 2015 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at:

Gayle Lantto, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00571	B. WING		05/1	4/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S T <b>HEAST FIR</b> S	STATE, ZIP CODE		
ST LUCA	AS CARE CENTER		LT, MN 5502			
(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	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	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 a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	the following licensicorrections are con on the bottom of the with "Laboratory Dieses."			Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

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

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00571	B. WING		05/14/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST LUCA	AS CARE CENTER		THEAST FIRE LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 000	Continued From pa	ige 1	2 000			
	these orders for you original to the address Minnesota Departm Health Regulation I P.O. Box 64900 St. Paul, MN 5516	nent of Health Division		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the finding are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Methologorection and the Time Period Four Correction.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." I the atute/rule sies" iply" his s which after the is veyors d of or  DING OF  TO . THIS	
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
	must be used by al care of the resident					
	This MN Requirem	ent is not met as evidenced				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 25 7RBT11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0.10
ST LUC	AS CARE CENTER		HEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	by: Based on observat review, the facility for 3 for residents (Findings include: R39's care plan revas follows: "The restwo staff with ambut two staff to transfer requests." On 3/11 the care plan that resident for prevent falls." R39 was observed p.m. The resident for 2:41 p.m. a registe the resident had "a on the evening shift did not work the evereceived a report the foot caught uncentral to the specific details of the specific details of the were involved or where involved resident leg gave in as she swollen. Assessed around to right ank to touch. When ask resident stated, 'It is [TMA-A]. The resident, it hurts.' The resident is the stated of the service of the stated of the service of	ion, interview and document ailed to follow the care plan 1 R39) reviewed for accidents.  vised 12/15/14, directed staff sident is to have assistance of alation and transfers, needs to/from toilet as she /15, an addition was made to ead, "assist of 2 for transfers  lying in bed on 5/11/15, at 2:00 had a cast on her right foot. At red nurse (RN)-B explained fractured ankle that occurred t on 4/14/15." Although RN-B ening of 4/14/15, she had be following day that R39 got der the bed during a transfer. did not, however, know any ne incident, such as what staff hen exactly the resident	2 565			

Minnesota Department of Health

STATE FORM 6899 7RBT11 If continuation sheet 3 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00571	B. WING	<del></del>	05/1	4/2015
	PROVIDER OR SUPPLIER	500 SOUT	DRESS, CITY, S HEAST FIRS			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	unable to recall."  During an interview DON reported R39 9:05 a.m. the DON RN-B reiterated that working at the time to her that R39 statishe got "her 'foot cathe DON reported state of the DON reported state of the reside and was unaware the sheets directed state of R39. When asket transferred the reside and was unaware the sheets directed state of R39. When asket transferred the reside only one person.  A policy for care plate provided.  SUGGESTED MET director of nursing of revise policies and the care plan for eat followed. A system staff and for monito quality committee of is sustained.	ge 3  on 5/13/15, at 9:00 a.m. the was known to self-transfer. At and RN-B were interviewed. It although she was not of R39's injury, it was reported ed at the time of the incident aught' in the bed." At 9:25 a.m. she did not know who had ent at the time of the incident, he care plan and the NA care ff to use a two person transfer ed if one person had dent the DON replied, "Yes."  p.m. NA-C said two staff osed to transfer the resident, f" transferred the resident with ans was requested and not THOD OF CORRECTION: The or designee could review and procedures related to ensuring ich individual resident is for educating appropriate ring could be developed. The ould review to ensure the plan R CORRECTION: Twenty-one	2 565			
21565	Medications Self Ac Subp. 4. Self-adm	inistration. A resident may	21565			
	self-administer med	dications if the comprehensive				

Minnesota Department of Health

STATE FORM 6899 7RBT11 If continuation sheet 4 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	:S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		K3) DATE SURVEY COMPLETED	
		00571	B. WING		05/1	14/2015	
NAME OF PROVIDER OR SUF	PLIER			STATE, ZIP CODE			
ST LUCAS CARE CENT	ER		THEAST FIRS LT, MN 5502				
PRÉFIX (EACH DEF	CIENC,	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
care as requi 4658.0405 in is a written or This MN Req by: Based on obserview, the faself-administry was completed received medication less and completed received medication less are supervision of the breakfast what kind of promorning."  R151 was neand did not him the time of the medical reconstructed memory (loss of vision R151's unsig did not direct the bedside. (dietary supercapsules dail	ssmered in dicate der from the cility of a cate of a cat	nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.  ent is not met as evidenced ion, interview and document failed to ensure of medication assessment 1 of 1 resident (R151) who n from the nurse without inistration and/or had	21565				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00571	B. WING		05/1	4/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502				
(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	
21565	40 mg daily, potass (for potassium deficition (MEQ) daily, calcium 1 tablet twice daily, constipation) 100 m (for iron deficiency a metoprolol tartrate (blood pressure) 50 gabapentin (for seiztimes daily. All medithe medication admadministered at 8:00 R151's medical recidetermine whether self-administer medications after been completed for R151 dated 5/6/ability to self-admin On 5/12/15, at 8:22 (DON) verified a SA been completed for R151's room, took to be deside table and repractical nurse (LPN On 5/12/15, at 8:25 not supposed to haw without confirming splace. LPN-A explainmedications after be the bedside table.  The DON then confinot have a SAM as stated she expected ensure residents we facility's policy.	ium chloride extended release siency) 20 mili-equivalent m-vitamin D 500-200 mg-unit docusate sodium (for ing twice daily, ferrous sulfate anemia) 325 mg twice daily, (for chest pain or to lower immage by mouth twice daily, and sure disorder) 300 mg three discations were scheduled in ministration record to be 0 a.m.  Ord lacked an assessment to the resident could safely lication (SAM). The care plan 15, did not address R151's ister medications.  a.m. director of nursing the same of the cup of pills from R151's eturned it to the licensed	21565				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00571	B. WING		05/1	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21565	Medications policy admission, nursing would like to self-act resident has expresself-administer, the assess the resident visual ability to carry facility may require the nurse until the copportunity to obtain make an assessme completed within set the comprehensive an order from the pof medications. Does self-administer medications. But the comprehensive an order from the pof medications. Suggested to self-administer medications are plant.  SUGGESTED MET director of nursing or residents who desir assessed as capable responsible for admitted been assessed as capable reproducted of medications. The the quality committed the self-administer medications. The the quality committed the self-administer medications who desir assessed as capable responsible for admitted the self-administer.	directed staff to: "Upon will ask each resident if they diminister medications. If the sed a desire to interdisciplinary team will its cognitive, physical and yout this responsibility. The that drugs be administered by care planning team has the information necessary to ent or until the care plan is even days upon completion of assessmentNursing to get hysician for self-administration cumentation of the ability to dications will appear on the it."  THOD OF CORRECTION: The or designee could ensure all the SAM are comprehensively le of doing so. Nursing staff ininistering medications could arding ensuring a resident has capable of SAM prior to insupervised with medications. In and audits could be results could be brought to	21565			
21620	MN Rule 4658.1345 Drugs used in the n in accordance with	ursing home must be labeled	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00571	B. WING		05/	14/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
ST LUC	AS CARE CENTER		THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 7	21620			
	by: Based on observati review the facility fa was not stored for u on the transitional o addition, the facility stocked medication the north-south cart (LTC), potentially af those units.  Findings include:  The facility's medica observed on the TC at 1:00 p.m. R16's at room temperatur date; the last refill of medication storage carts on the TCU at	on, interview and document alled to ensure undated insulinguse for 1 of 3 residents (R16) care unit (TCU) cart 2. In failed to remove expired son the TCU cart 1 and 2 and to on the long term care unit fecting the 34 residents on attorned by the son the total and the son the total and the son the total and the son the son the total and the son the son the son the total and the son the total and the son t				
	inflammation) 325 r opened date of 1/20 11/20/14, and the so of 4/15; 2) folic acid (to pro- 0.4 mg with an open expiration date of 3	spirin (for pain, fever, milligrams (mg) one with an 0/15, and expiration date of econd with an expiration date duce and maintain new cells) ned date of 6/1/14, and /15; revent urinary tract infections)				
	450 mg with on ope expiration date of 6, 4) geri-lanta (for he opened date of 2/4/ 11/14; 5) ultratuss expector	ened date of 12/16/14, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	3/15; 6) calcium 500 mg and expiration date 7) zinc sulfate (mine opened date of 6/26 9/14.  R16's physician ord the resident's insuliand documented. Fadministration recording and interview licensed practical nundated insulin for at room temperatur opened date. LPN-stocked medication and should have be placed in the storage.  During an interview director of nursing (lacked an opened of medications were in explained that staff expiration dates, date expiration dates, date expiration dates, date of that Novolog mix 70 once opened.  A registered nurse of 5/11/15, at approximation dates on 5/11/15, at approximation dates.	with an opened date of 3/6/15, of 3/15; and eral supplement) with an 6/14, and expiration date of ders dated 4/30/15, indicated in use was to be monitored at 6's 5/15 medication and (MAR) directed staff to mix 70/30 suspension ous of 30 units daily at 7:30 aily at 5:30 p.m.  on 5/11/15, at 1:00 p.m. a urse (LPN)-B confirmed the R16 had been stored for use e on cart 2, and lacked an B confirmed the expired on cart 1 and 2 had expired on cart 1 and 2 had expired en removed from the cart and ge room for destruction.  on 5/11/15, at 1:29 p.m. the DON) verified R16's insuling late and the stocked house indeed expired. The DON was to check medications for the insulins with opened and move any expired medications in carts, and place the items in or destruction. The DON stated 0/30 was viable for 28 days  (RN)-B verified in an interview eximately 1:45 p.m. that the	21620			
	on 5/11/15, at appropriate the stock medical					

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY OMPLETED	
		00571	B. WING		05/1	4/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
ST LUCA	S CARE CENTER		HEAST FIRS				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE	
21620	Continued From pa	ge 9	21620				
	the expired medications should have been removed from the medication cart for destruction.						
	indicated ino discordeteriorated medicathis facility. All such The manufacturer's mix 70/30 noted ins	Medications: Storage of policy nationed, outdated or ations are available for use in medications are destroyed." a package insert for Novolog sulin should have been days, even if insulin remained					
	director of nursing (pharmacist ensure medication storage educated as necess labeling medication expired medications along with the pharmedications on a recompliance.	THOD OF CORRECTION: The (DON) with the consulting policies adequately address. Nursing staff could be sary to the importance of s properly and discarding s. The DON or designee, macist, could audit egular basis to ensure					
	(14) days.	CONNECTION. Fourteen					
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805				
	residents have the courtesy and respe-	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by:	ent is not met as evidenced on, interview and document					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	14/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
ST LUC	AS CARE CENTER		HEAST FIRS _T, MN 5502			
(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 APPRODERICENCY)	JLD BE	(X5) COMPLETE DATE
21805	review, the facility fa assistance for 4 of R103), who were defor eating.  Findings include:  The evening meal s 5/11/15, from 6:00 t R12, R18, R96, and same table. A nursi registered nurse (R residents with their feeding the resident NA-A fed R96 and R12. R12 intermitte and fluids througho their back to the firs second, and then to second while assist At the end of the monormal to the second while assist At the end of the monormal to the unit, but were and NA-A each stat between two reside eat.  NA-B was interview NA-B sat while feed encouraging another normally staff sat be assisting with eating were "new."  The following day a and R103 were again and were assisted to stood while periodic stood while stood while stood st	ge 10  ailed to provide dignified dining 4 residents (R12, R18, R96, ependent on staff assistance)  service was observed on 6 6:41 p.m. Four residents, d R103 were seated at the 19 assistant (NA)-A and a 19 A each assisted two 19 meal. Both staff stood while 19 ts throughout the entire meal. R18, and RN-A fed R103 and 19 ently coughed/choked on food 19 the meal. Both staff turned 19 tresident while assisting the 19 urned their back toward the 19 ing the first, and so on.  19 ala t 6:41 p.m. RN-A and 19 d they did not normally work 19 e "filling in" that shift. RN-A 19 ed they normally stood 19 not mally stood 19 not swhile assisting them to 19 ed on 5/11/15, at 6:50 p.m. Sing one resident and 19 er resident to eat. NA-B stated 19 eside a resident while 19 eg, however, RN-A and NA-A 19 eat their breakfast. RN-C 19 eatly assisting residents with 19 ionally, RN-C 19 eft the table and 19 er 19 eatler 19 eat	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST LUC	AS CARE CENTER		THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	returned several times such as obtaining juexplained it was earesidents to ensure room during the methem to eat.  Following breakfast about breakfast, ho answer any question R12's care plan dat chewing difficulty sedementiaI have in [related to] wt loss, evidenced by] signification monitoring for signification with eating and drink monitoring for significati	nes to complete other tasks slice for a resident, etc. RN-C sier for her to monitor the they did not leave the dining ral if she stood while assisting at 8:50 a.m. R103 was asked wever, he was unable to ns.  ed 2/8/13, revealed, I have econdary to advanced radequate oral intake r/t fair appetite, AEB [as ficant weight loss x 1, 3, and 6 e intake at mealsI have ally lost weight d/t ase process] despite nutrition ventions included assisting king as necessary, as well as and symptoms of chewing, reting of food. R12 was to be areed diet with nectar thick then meal supplementation.  ed 11/14/14, showed, "I am at the hydration r/t dependence on the hydration r/t dependence on the hydration directed staff to offer d to monitor for signs and attion (inhalation of food or	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00571	B. WING		05/	14/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
ST LUC	ST LUCAS CARE CENTER 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
21805	majority of meals maintaining weight staffs' assistance at R103's care plan da inadequate oral inta recordsI feed mys staff cues and enco never been a big ea encouraging intake  The director of nurs 5/13/15, at 10:46 a. expectation staff sa residents while assis said it was "unacce resident while assis at 8:39 a.m. the DC needed assistance  The facility's 8/13, F directed staff to "pro socializing atmosph Quality of LifeDigr resident shall be ca promotes and enha respect, and individ  SUGGESTED MET director of nursing v designee could ens reflect the provision for all residents. Er re-educated on thes could be conducted assisted with meals manner, with the re the quality committee	"The goals included and interventions included to mealtime."  ated 5/2/14, noted, "I have ake r/t dementia ABE intake self with set-up assist, but the burages me to eat. I have ater." Interventions included at meals.  Sing (DON) was interviewed on m. The DON stated it was heret and had conversation with asting them to eat. The DON ptable" to stand over a sting them to eat. On 5/14/15, NN explained R103 periodically to eat.  Resident's Dining Room policy ovide residents with a here at mealtimes." A 1/14, hity policy noted, "Each red for in a manner that ances quality of life, dignity, uality."  CHOD OF CORRECTION: The with the social service ure polices and procedures of dignified care and services in a safe and dignified sults of the audits brought to						

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING.				
		00571	B. WING		05/1	4/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21805	Continued From page 13		21805				
	(14) days.						
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults		21990				
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify the caregiver, the naturnal treatment, any emaltreatment, the noreporter, the time, concident, and any of reporter believes must be suspected malting reporter may disclosin section 13.02, and section 144.335, to comply with this sulfate.						
	by: Based on observati review the facility fa investigation to rule	on, interview and document illed to complete an thorough out potential neglect of care R39) who sustained a fracture					
	Findings include:						
		lying in bed on 5/11/15, at 2:00 ad a cast on her right foot. An the resident was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	4/2010
	AS CARE CENTER		HEAST FIRS			
FARIBAU			LT, MN 5502			
(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
21990	Continued From pa	ge 14	21990			
	(RN)-B explained the ankle that occurred 4/14/15." Although of 4/14/15, she had following day that R the bed during a tranot, however, know incident, such as when exactly the resident is to he with ambulation and transfer to/from toile 3/11/15, an addition	p.m. a registered nurse ne resident had "a fractured on the evening shift on RN-B did not work the evening received a report the 139 got her foot caught under ansfer. RN-B reported she did of any specific details of the that staff were involved or sident sustained the injury.  39 revised 12/15/14, indicated have assistance of two staff of transfers, needs two staff to et as she requests." On have made to the care plan 2 for transfers to prevent				
	3/6/15, revealed dia and stroke. R39 wa required extensive daily living (ADLs) s	imum Data Set (MDS) dated agnoses including dementia is cognitively impaired and assistance for activities of such as transfers, locomotion dressing and toileting.				
	"Licensed practical from the trained me they noted resident leg gave in as she s swollen. Assessed around to right ankl to touch. When ask resident stated, 'It g [TMA-A]. The resident wrong, it hurts.' The what that statement	ted 4/15/15, at 6:37 a.m. read, nurse [LPN-C] was informed edication assistant [TMA-A], had difficulty standing; right stood. Right ankle was right ankle, swelling noted all e. No bruising noted. Tender ed resident what happened, got caught under the bed' per ent stated, 'She put it on e nurse [LPN-C] asked her t meant and the resident was e director of nursing [DON]				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00571	B. WING		05/1	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STIUCAS CARE CENTER			HEAST FIRS			
			LT, MN 5502		ONI	0/5
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 15	21990			
		k. Family will be called today due to no serious injury."				
	who were interview cared for the reside how the injury occu the resident was inj investigative interviews lack approximate times. R39. In addition, no had provided cares the resident to bed were as follows:  1) NA-C reported, "bathroom, but didn'	al investigation revealed staff ed reported they had either not ent, had no knowledge as to rred, and/or had not noticed ured. The facility's ews were all dated 4/15/15. ed information as to even the various staff cared for one of the staff verified who such as toileting and assisting on 4/14/15. The interviews  She took the resident to the t see any swelling to ankle ar weight. States she didn't				
	2) NA-D's interview indicated, "She gave [R39] a shower on 4/14/15, and the right ankle was not swollen and the resident did not have pain."					
		interview read, "[R39] couldn't noted her right ankle was he [TMA-A] know."				
	4) TMA-A's intervied nurse and the nurse	w showed, "She informed the elevated the leg."				
	DON reported she was reported her foot was DON stated R39 was 9:05 a.m. the DON RN-B reiterated that working at the time	on 5/13/15, at 9:00 a.m. the was unaware R39 had as caught in the bed. The as known to self-transfer. At and RN-B were interviewed. It although she was not of R39's injury, it was reported ed at the time of the incident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST LUC	AS CARE CENTER		THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	she got "her 'foot cathe DON reported so cared for the reside and was unaware the sheets directed state for R39. When asked transferred the reside and some considerable of the policy o	ge 16 aught' in the bed." At 9:25 a.m. she did not know who had ant at the time of the incident, he care plan and the NA care if to use a two person transfer ed if one person had dent the DON replied, "Yes."  a.m. the DON reviewed the mitted to the designated State read, "On 4/14/15, [R39] was and noted that resident had and right leg gave out. [LPN-C] is swollen and not bruise [sic]. It is sessed again and x-ray [sic]. It is shower and skin one but on 4/14/15 evening 7:30 p.m.] it was noted. [R39] and self propels down the and activities. It is also possible that ankle against something and self propels down the adactivities. It is also possible that ankle against something and self propels down the adactivities. It is also possible that ankle against something and self propels down the adactivities. It is also possible that ankle against something and self propels down the plan, care data sheets, the plan assisted the resident to the	21990			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  21990  Continued From page 17  for caring for R39 the evening shift of 4/14/15.  NA-C responded, "everyone helps" and again denied that although she was listed as primarily responsible for R39, that she had assisted her with transferring during the evening shift on 4/14/15. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. NA-C stated R39 was not exhibiting any signs of ankle pain at the time she worked with her, nor did she know how the injury occurred. Other staff who may have assisted R39 the evening of 4/14/15, were unavailable for an interview.  The facility's 1/3/14, Abuse Prevention Plan indicated staff would ensure neglect was minimized by "The assignment of a sufficient number of staff on each shift to meet the needs of the residents, and assure the staff assigned has knowledge of individual care needs." In addition, the policy read, "Facility will investigate all incidences of falls, bruising, medication error, resident complaints, etcThe facility identify the staff member responsible forinvestigation of the event and implements immediate changes to keep the resident safe; with follow	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  ST LUCAS CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  ((A4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COMPLETIVE TAG  COntinued From page 17  for caring for R39 the evening shift of 4/14/15. NA-C responded, "everyone helps" and again denied that although she was listed as primarily responsible for R39, that she had assisted her with transferring during the evening shift on 4/14/15. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. NA-C stated R39 was not exhibiting any signs of ankle pain at the time she worked with her, nor did she know how the injury occurred. Other staff who may have assisted R39 the evening of 4/14/15, were unavailable for an interview.  The facility's 1/3/14, Abuse Prevention Plan indicated staff would ensure neglect was minimized by "The assignment of a sufficient number of staff on each shift to meet the needs of the residents, and assure the staff assigned has knowledge of individual care needs." In addition, the policy read, "Facility will investigate all incidences of falls, bruising, medication error, resident complaints, etc The facility identify the staff member responsible for investigation of the event and implements immediate changes to keep the resident safe; with follow		00574	B WING		05/4	4/0045
ST LUCAS CARE CENTER  500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021    X41   ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   ID PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  21990   Continued From page 17   Continued From page 17   For caring for R39 the evening shift of 4/14/15. NA-C responded, "everyone helps" and again denied that although she was listed as primarily responsible for R39, that she had assisted her with transferring during the evening shift on 4/14/15. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. NA-C stated R39 was not exhibiting any signs of ankle pain at the time she worked with her, nor did she know how the injury occurred. Other staff who may have assisted R39 the evening of 4/14/15, were unavailable for an interview.  The facility's 1/3/14, Abuse Prevention Plan indicated staff would ensure neglect was minimized by "The assignment of a sufficient number of staff on each shift to meet the needs of the residents, and assure the staff assigned has knowledge of individual care needs." In addition, the policy read, "Facility will investigate all incidences of falls, bruising, medication error, resident complaints, etcThe facility identify the staff member responsible forinvestigation of the event and implements immediate changes to keep the resident safe; with follow		00571	D. W. KG		05/1	4/2015
ST LUCAS CARE CENTER   FARIBAULT, MN 55021	NAME OF PROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    21990   Continued From page 17   21990   21990    21990   Continued From page 17   21990	ST LUCAS CARE CENTER	FNTFR				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  21990  Continued From page 17  for caring for R39 the evening shift of 4/14/15. NA-C responded, "everyone helps" and again denied that although she was listed as primarily responsible for R39, that she had assisted her with transferring during the evening shift on 4/14/15. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. NA-C stated R39 was not exhibiting any signs of ankle pain at the time she worked with her, nor did she know how the injury occurred. Other staff who may have assisted R39 the evening of 4/14/15, were unavailable for an interview.  The facility's 1/3/14, Abuse Prevention Plan indicated staff would ensure neglect was minimized by "The assignment of a sufficient number of staff on each shift to meet the needs of the residents, and assure the staff assigned has knowledge of individual care needs." In addition, the policy read, "Facility will investigate all incidences of falls, bruising, medication error, resident complaints, etcThe facility identify the staff member responsible forinvestigation of the event and implements immediate changes to keep the resident safe; with follow	FARIBAU		JLI, MN 5502			
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up/implementation to make sure they are appropriate for resident and condition of resident." Under internal reporting the policy directed staff to conduct a physical assessment of the resident, speaking to all staff involved in the situation and document such findingsThe documentation will include the following: Identity of the resident, Identity of the caregiver," as well as the time, date, location, nature and extent, and any other information helpful in investigating the situation. Staff were to then"Analyze occurrences to determine what changes are needed if any in	for caring for R39 the NA-C responded, "edenied that although responsible for R39, with transferring durit 4/14/15. NA-C said to supposed to transfer staff" transferred the person. NA-C stated signs of ankle pain a her, nor did she know Other staff who may evening of 4/14/15, vinterview.  The facility's 1/3/14, indicated staff would minimized by "The anumber of staff on eof the residents, and has knowledge of incaddition, the policy reall incidences of falls resident complaints, staff member responsevent and implement keep the resident saup/implementation to appropriate for resident." Under intedirected staff to concord the resident, speathe situation and documentation will in of the resident, Identas the time, date, locany other information situation. Staff were	g for R39 the evening shift of 4/14/15. sponded, "everyone helps" and again at although she was listed as primarily ble for R39, that she had assisted her aferring during the evening shift on NA-C said two staff persons were do to transfer the resident, but said "some afferred the resident with only one NA-C stated R39 was not exhibiting any ankle pain at the time she worked with did she know how the injury occurred. If who may have assisted R39 the of 4/14/15, were unavailable for an staff would ensure neglect was do by "The assignment of a sufficient of staff on each shift to meet the needs sidents, and assure the staff assigned wledge of individual care needs." In the policy read, "Facility will investigate nees of falls, bruising, medication error, complaints, etcThe facility identify the inber responsible forinvestigation of the dimplements immediate changes to resident safe; with follow mentation to make sure they are ate for resident and condition of "Under internal reporting the policy staff to conduct a physical assessment sident, speaking to all staff involved in item and document such findingsThe station will include the following: Identity sident, Identity of the caregiver," as well ne, date, location, nature and extent, and information helpful in investigating the Staff were to then "Analyze occurrences to the staff were to the staff were to th				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00571	B. WING		05/1	4/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 33/1	.,
ST LUCA	AS CARE CENTER		HEAST FIRS			
(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
21990	Continued From pa	ge 18	21990			
	investigation included noted "Each and exinternal investigation intervention at the t	s of potential neglect requiring ed fractures. The policy also very incident will have an nAll incidents will have an ime of the incident and care to reduce the chances of a				
	SUGGESTED METHOD OF CORRECTION: The social service designee with the director of nursing could ensure all injuries of unknown origin are investigated thoroughly to ensure the resident and all appropriate staff are interviewed and care plans were followed to determine whether potential neglect of care/supervision may have occurred. Policies could be reviewed and revised as necessary, and appropriate staff trained. Audits for monitoring purposes could be conducted and the results of the audits brought to the quality committee for review.					
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
22000	MN St. Statute 626 Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may eand a statement of to minimize the risk	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan	22000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 00/1	1/2010
	AS CARE CENTER		HEAST FIRS			
SI LUCA	AS CARE CENTER	FARIBAU	LT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	(b) Each facility, agency and person providers, shall dev prevention plan for residing there or reconstruction of the plan shall control assessment of: (1) abuse by other indivulnerable adults; (1) other vulnerable adults; (2) other vulnerable adspecific measures the risk of abuse to that adults. For the purpler "abuse" included (c) If the facility, and personal care as knows that the vulnerable to the plan must detail the minimize the risk the reasonably be experimentally and persons unsupervised. Under the plan must detail the minimize the risk the reasonably and persons unsupervised. Under the plan must detail the minimize the risk the reasonably and persons unsupervised. Under the plan must detail the minimize the risk the reasonably of a vulnerable adult misconduct or physical information from authority or through another facility, and	including a home health care all care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the	22000			
	by:	ent is not met as evidenced on, interview, and document				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STIUCAS CARE CENTER			HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	review, the facility faconducting a thorouneglect of care for a sustained a fracture. Findings include:  The facility's 1/3/14 indicated staff would minimized by "The anumber of staff on of the residents, and has knowledge of in addition, the policy all incidences of fall resident complaints staff member responsive to the resident staff member responsive the resident." Under interested staff to complaint of the resident, specified the situation and do documentation will of the resident, lder as the time, date, loany other information situation. Staff were to determine what of policy and procedur occurrences." Signs investigation include noted "Each and every sustained to the situation of the resident of the r	ailed to follow their policy for agh investigation into potential of 1 resident (R39) who e of unknown origin.  Abuse Prevention Plan densure neglect was assignment of a sufficient each shift to meet the needs deasure the staff assigned ndividual care needs." In read, "Facility will investigate ls, bruising, medication error, or, etcThe facility identify the ensible forinvestigation of the ints immediate changes to	22000			
	intervention at the ti	ime of the incident and care to reduce the chances of a				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.1.12 1 27.11			A. BUILDING:			
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	R39 was observed p.m. The resident h 5/11/15, at 2:41 p.m explained the residuoccurred on the ever Although RN-B did 4/14/15, she had reday that R39 got heduring a transfer. R however, know any such as what staff the resident sustain. The care plan for R "The resident is to hwith ambulation and transfer to/from toilu 3/11/15, an addition that read, "assist of falls."  R39's quarterly Min 3/6/15, revealed dia and stroke. R39 warequired extensive daily living (ADLs) son and off the unit,  A progress note da "Licensed practical from the trained methey noted resident leg gave in as she s swollen. Assessed around to right anklito touch. When ask resident stated, 'It g [TMA-A]. The resid wrong, it hurts.' The	lying in bed on 5/11/15, at 2:00 and a cast on her right foot. At a. a registered nurse (RN)-B ent had "a fractured ankle that ening shift on 4/14/15." not work the evening of eceived a report the following er foot caught under the bed in the reported she did not, a specific details of the incident, were involved or when exactly	22000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
<u>l</u> _	00571	B. WING		05/1	4/2015
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ST LUCAS CARE CENTER		THEAST FIRS LT, MN 5502			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C 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
notified via notebook. at appropriate time dual time dual The facility's internal is who were interviewed cared for the resident how the injury occurrent the resident was injurinvestigative interview. The interviews lacked approximate times the R39. In addition, none had provided cares so the resident to bed or were as follows:  1) NA-C reported, "Sh bathroom, but didn't so and was able to bear transfer to bed."  2) NA-D's interview in shower on 4/14/15, as swollen and the resident and he let the swollen and he let the Universe and the nurse of Don reported she was pont attended to the swollen and the resident and the nurse and the foot was pont stated R39 was	director of nursing [DON]. Family will be called today ue to no serious injury."  investigation revealed staff direported they had either not the today as to ed, and/or had not noticed red. The facility's was were all dated 4/15/15. It information as to even e various staff cared for e of the staff verified who uch as toileting and assisting in 4/14/15. The interviews  the took the resident to the see any swelling to ankle weight. States she didn't endicated, "She gave [R39] a nd the right ankle was not lent did not have pain."  terview read, "[R39] couldn't oted her right ankle was e [TMA-A] know."  showed, "She informed the elevated the leg."  on 5/13/15, at 9:00 a.m. the as unaware R39 had a caught in the bed. The sknown to self-transfer. At and RN-B were interviewed.	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ST LUC	AS CARE CENTER		HEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	to her that R39 stat she got "her 'foot cat the DON reported scared for the reside and was unaware the sheets directed stat for R39. When aske transferred the reside and state of R39. When aske transferred the reside on 5/13/15, at 9:15 incident report subragency (SA) which transferred and [NA difficulty standing a noted that area was On 4/15/15, area as X-ray resulted in no malleolus inferiorly. transfersStaff had assessment was do shift around 1930 [7 does self transfers hallway to meals are that she could have causing the break plan of care by care communication boomedical record."	ed at the time of the incident aught' in the bed." At 9:25 a.m. whe did not know who had ant at the time of the incident, he care plan and the NA care if to use a two person transfer ed if one person had dent the DON replied, "Yes."  a.m. the DON reviewed the mitted to the designated State read, "On 4/14/15, [R39] was and included that resident had and right leg gave out. [LPN-C] is swollen and not bruise [sic]. In displaced fracture lateral [R39] stated it was twisted on a given her a shower and skin one but on 4/14/15 evening and self propels down the and activities. It is also possible that ankle against something staff are made aware of the eplan, care data sheets, the ok, nursing report, and the	22000			
	worked with R39 th NA-C reported she room to stand her user incontinence, and the down. She denied bathroom and again up" and checked he NA-C did not know dining room, or who	p.m. NA-C verified she had e evening shift on 4/14/15. had "only" walked into R39's up in her chair and check for men assisted her to sit back transferring the resident to the n stated she "just stood her er prior to the evening meal. who took escorted R39 to the o had assisted the resident to vening shift. NA-C was shown				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00571	B. WING		05/1	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST LUC	AS CARE CENTER		THEAST FIRS LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
22000	a sheet identifying hear for caring for R39 th NA-C responded, "edenied that although responsible for R39 with transferring dud 4/14/15. NA-C said supposed to transferstaff" transferred the person. NA-C states signs of ankle pain her, nor did she known Other staff who may evening of 4/14/15, interview.  SUGGESTED MET social service designursing could ensure followed regarding in unknown origin for care/supervision may could be reviewed appropriate staff trapurposes could be of the audits brought to review.	ner as the person responsible the evening shift of 4/14/15. Everyone helps" and again the she was listed as primarily that she had assisted her ring the evening shift on two staff persons were the resident, but said "some the resident with only one do R39 was not exhibiting any at the time she worked with the work the injury occurred. If y have assisted R39 the were unavailable for an a the time with the director of the facility policies were nvestigating all injuries of	22000			

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