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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7RBT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**
2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/07/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
07/27

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 07/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/17/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245067	A. Building B. Wing	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** Reg. # **483.10(n)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/23/2015**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/23/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	07/07/2015	15507	07/07/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/14/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245067	A. Building B. Wing **01 - MAIN BUILDING 01**	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
ID Prefix	Correction Completed **06/23/2015**	ID Prefix	Correction Completed **06/23/2015**	ID Prefix	Correction Completed **06/23/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0045		LSC K0070	
ID Prefix	Correction Completed **06/23/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	07/07/2015	25822	06/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/12/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7RBT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/14/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
07/27

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

12.Total Facility Beds **109** (L18)

13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sandra Tatro, HFE NEII — 06/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 06/17/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 06/17/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

Remedies - 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;

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED JUN 15 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure self-administration of medication assessment was completed for 1 of 1 resident (R151) who received medication from the nurse without supervision of administration and/or had medication left at bedside. Findings include: R151 was observed in her room on 5/12/15, at 8:18 a.m. A pill cup, half full of medications and glass of water were on the resident's bedside table. R151 explained she took the medications after eating breakfast, and she was waiting for	F 176	Resident (R151) was reassessed 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. 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.	

POC accepted as for this 6/16/15

Scanned 6/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6-9-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 176	Continued From page 1 her breakfast to arrive. R151 stated, "I don't know what kind of pills are these, but I take pills every morning." R151 was newly admitted to the facility on 5/6/15, and did not have Minimum Data Set completed at the time of the observation. The electronic medical record identified R151's diagnoses to include memory loss and unspecified glaucoma (loss of vision). R151's unsigned physician's orders dated 5/6/15, did not direct the staff to leave the medications at the bedside. Orders included: fish oil capsule (dietary supplement) 1000 mg (milligrams) 2 capsules daily, furosemide (to remove excess fluid from the tissues) 40 mg daily, lansoprazole 30 mg daily, Lisinopril (to lower blood pressure) 40 mg daily, potassium chloride extended release (for potassium deficiency) 20 mili-equivalent (MEQ) daily, calcium-vitamin D 500-200 mg-unit 1 tablet twice daily, docusate sodium (for constipation) 100 mg twice daily, ferrous sulfate (for iron deficiency anemia) 325 mg twice daily, metoprolol tartrate (for chest pain or to lower blood pressure) 50 mg by mouth twice daily, and gabapentin (for seizure disorder) 300 mg three times daily. All medications were scheduled in the medication administration record to be administered at 8:00 a.m. R151's medical record lacked an assessment to determine whether the resident could safely self-administer medication (SAM). The care plan for R151 dated 5/6/15, did not address R151's ability to self-administer medications. On 5/12/15, at 8:22 a.m. director of nursing (DON) verified a SAM assessment had not yet	F 176	Facility SAM policy and procedure was reviewed and remains current. Weekly random audits will be conducted on each nursing unit for 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 Date of completion: 6-23-15	

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F 176	Continued From page 2 been completed for R151. The DON then entered R151's room, took the cup of pills from R151's bedside table and returned it to the licensed practical nurse (LPN)-A. On 5/12/15, at 8:25 a.m. LPN-A stated she was not supposed to have left medications with R151 without confirming she had a SAM assessment in place. LPN-A explained R151 wanted to take her medications after breakfast, so they were left on the bedside table. The DON then confirmed at 8:26 a.m. R151 did not have a SAM assessment completed and stated she expected the nurses to supervise and ensure residents were taking medications per the facility's policy. The facility's 8/13, Self-Administration of Medications policy directed staff to: "Upon admission, nursing will ask each resident if they would like to self-administer medications. If the resident has expressed a desire to self-administer, the interdisciplinary team will assess the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require that drugs be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make an assessment or until the care plan is completed within seven days upon completion of the comprehensive assessment...Nursing to get an order from the physician for self-administration of medications. Documentation of the ability to self-administer medications will appear on the resident's care plan."	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 3 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	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 all staff involved in the incident, identification of alleged staff member, identification of the resident, and interventions implemented to prevent a recurrence of the incident.	

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete an thorough investigation to rule out potential neglect of care for 1 of 1 resident (R39) who sustained a fracture of unknown origin. Findings include: R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. An attempt to interview the resident was unsuccessful. On 5/11/15, at 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. The care plan for R39 revised 12/15/14, indicated "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39's quarterly Minimum Data Set (MDS) dated 3/6/15, revealed diagnoses including dementia and stroke. R39 was cognitively impaired and required extensive assistance for activities of daily living (ADLs) such as transfers, locomotion	F 225	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 recommendations. Ongoing monitoring to ensure compliance will be conducted by the Administrator or designee through investigation report review to assure investigations are thorough and accurate. Date of completion: 6-23-15	

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F 225	Continued From page 5 on and off the unit, dressing and toileting. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was unable to recall. The director of nursing [DON] notified via notebook. Family will be called today at appropriate time due to no serious injury." The facility's internal investigation revealed staff who were interviewed reported they had either not cared for the resident, had no knowledge as to how the injury occurred, and/or had not noticed the resident was injured. The facility's investigative interviews were all dated 4/15/15. The interviews lacked information as to even approximate times the various staff cared for R39. In addition, none of the staff verified who had provided cares such as toileting and assisting the resident to bed on 4/14/15. The interviews were as follows: 1) NA-C reported, "She took the resident to the bathroom, but didn't see any swelling to ankle and was able to bear weight. States she didn't transfer to bed." 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."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 6 3) NA-A's reported interview read, "[R39] couldn't bear weight and he noted her right ankle was swollen and he let the [TMA-A] know." 4) TMA-A's interview showed, "She informed the nurse and the nurse elevated the leg." During an interview on 5/13/15, at 9:00 a.m. the DON reported she was unaware R39 had reported her foot was caught in the bed. The DON stated R39 was known to self-transfer. At 9:05 a.m. the DON and RN-B were interviewed. RN-B reiterated that although she was not working at the time of R39's injury, it was reported to her that R39 stated at the time of the incident she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes." On 5/13/15, at 9:15 a.m. the DON reviewed the incident report submitted to the designated State agency (SA) which read, "On 4/14/15, [R39] was transferred and [NA-A] noted that resident had difficulty standing and right leg gave out. [LPN-C] noted that area was swollen and not bruise [sic]. On 4/15/15, area assessed again and x-ray [sic]. X-ray resulted in non-displaced fracture lateral malleolus inferiorly. [R39] stated it was twisted on transfers...Staff had given her a shower and skin assessment was done but on 4/14/15 evening shift around 1930 [7:30 p.m.] it was noted. [R39] does self transfers and self propels down the hallway to meals and activities. It is also possible that she could have hit ankle against something	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 7 causing the break...Staff are made aware of the plan of care by care plan, care data sheets, the communication book, nursing report, and the medical record." On 5/13/15, at 2:25 p.m. NA-C verified she had worked with R39 the evening shift on 4/14/15. NA-C reported she had "only" walked into R39's room to stand her up in her chair and check for incontinence, and then assisted her to sit back down. She denied transferring the resident to the bathroom and again stated she "just stood her up" and checked her prior to the evening meal. NA-C did not know who took escorted R39 to the dining room, or who had assisted the resident to use the toilet that evening shift. NA-C was shown a sheet identifying her as the person responsible 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	F 225		

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	245067	A. BUILDING _____ B. WING _____	05/14/2015

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F 225	Continued From page 8 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 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 findings...The 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 policy and procedures to prevent further occurrences." Signs of potential neglect requiring investigation included fractures. The policy also noted "Each and every incident will have an internal investigation...All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 226	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.	

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F 226	Continued From page 9 review, the facility failed to follow their policy for conducting a thorough investigation into potential neglect of care for 1 of 1 resident (R39) who sustained a fracture of unknown origin. Findings include: 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 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 findings...The 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 policy and procedures to prevent further occurrences." Signs of potential neglect requiring investigation included fractures. The policy also noted "Each and every incident will have an internal investigation...All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident."	F 226	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 all 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 ensure compliance will be conducted by the Administrator and/or designee through investigation report review to assure investigations are thorough and accurate. Date of completion: 6-23-15	

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F 226	Continued From page 10 R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. At 5/11/15, at 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. The care plan for R39 revised 12/15/14, indicated "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39's quarterly Minimum Data Set (MDS) dated 3/6/15, revealed diagnoses including dementia and stroke. R39 was cognitively impaired and required extensive assistance for activities of daily living (ADLs) such as transfers, locomotion on and off the unit, dressing and toileting. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on	F 226		

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F 226	Continued From page 11	F 226		

wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was unable to recall. The director of nursing [DON] notified via notebook. Family will be called today at appropriate time due to no serious injury."

The facility's internal investigation revealed staff who were interviewed reported they had either not cared for the resident, had no knowledge as to how the injury occurred, and/or had not noticed the resident was injured. The facility's investigative interviews were all dated 4/15/15. The interviews lacked information as to even approximate times the various staff cared for R39. In addition, none of the staff verified who had provided cares such as toileting and assisting the resident to bed on 4/14/15. The interviews were as follows:

1) NA-C reported, "She took the resident to the bathroom, but didn't see any swelling to ankle and was able to bear weight. States she didn't transfer to bed."

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."

3) NA-A's reported interview read, "[R39] couldn't bear weight and he noted her right ankle was swollen and he let the [TMA-A] know."

4) TMA-A's interview showed, "She informed the nurse and the nurse elevated the leg."

During an interview on 5/13/15, at 9:00 a.m. the DON reported she was unaware R39 had reported her foot was caught in the bed. The DON stated R39 was known to self-transfer. At

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F 226	Continued From page 12 9:05 a.m. the DON and RN-B were interviewed. RN-B reiterated that although she was not working at the time of R39's injury, it was reported to her that R39 stated at the time of the incident she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes." On 5/13/15, at 9:15 a.m. the DON reviewed the incident report submitted to the designated State agency (SA) which read, "On 4/14/15, [R39] was transferred and [NA-A] noted that resident had difficulty standing and right leg gave out. [LPN-C] noted that area was swollen and not bruise [sic]. On 4/15/15, area assessed again and x-ray [sic]. X-ray resulted in non-displaced fracture lateral malleolus inferiorly. [R39] stated it was twisted on transfers...Staff had given her a shower and skin assessment was done but on 4/14/15 evening shift around 1930 [7:30 p.m.] it was noted. [R39] does self transfers and self propels down the hallway to meals and activities. It is also possible that she could have hit ankle against something causing the break...Staff are made aware of the plan of care by care plan, care data sheets, the communication book, nursing report, and the medical record." On 5/13/15, at 2:25 p.m. NA-C verified she had worked with R39 the evening shift on 4/14/15. NA-C reported she had "only" walked into R39's room to stand her up in her chair and check for incontinence, and then assisted her to sit back down. She denied transferring the resident to the bathroom and again stated she "just stood her	F 226		

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F 226	Continued From page 13 up" and checked her prior to the evening meal. NA-C did not know who took escorted R39 to the dining room, or who had assisted the resident to use the toilet that evening shift. NA-C was shown a sheet identifying her as the person responsible 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.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified dining assistance for 4 of 4 residents (R12, R18, R96, R103), who were dependent on staff assistance for eating. Findings include:	F 241	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.	

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F 241	Continued From page 14 The evening meal service was observed on 5/11/15, from 6:00 to 6:41 p.m. Four residents, R12, R18, R96, and R103 were seated at the same table. A nursing assistant (NA)-A and a registered nurse (RN)-A each assisted two residents with their meal. Both staff stood while feeding the residents throughout the entire meal. NA-A fed R96 and R18, and RN-A fed R103 and R12. R12 intermittently coughed/choked on food and fluids throughout the meal. Both staff turned their back to the first resident while assisting the second, and then turned their back toward the second while assisting the first, and so on. At the end of the meal at 6:41 p.m. RN-A and NA-A both explained they did not normally work on the unit, but were "filling in" that shift. RN-A and NA-A each stated they normally stood between two residents while assisting them to eat. NA-B was interviewed on 5/11/15, at 6:50 p.m. NA-B sat while feeding one resident and encouraging another resident to eat. NA-B stated normally staff sat beside a resident while assisting with eating, however, RN-A and NA-A were "new." The following day at 8:36 a.m. R12, R18, R96, and R103 were again seated at a table together and were assisted to eat their breakfast. RN-C stood while periodically assisting residents with bites of food. Additionally, RN-C left the table and returned several times to complete other tasks such as obtaining juice for a resident, etc. RN-C explained it was easier for her to monitor the residents to ensure they did not leave the dining room during the meal if she stood while assisting them to eat.	F 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	

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F 241	Continued From page 15 Following breakfast at 8:50 a.m. R103 was asked about breakfast, however, he was unable to answer any questions. R12's care plan dated 2/8/13, revealed, I have chewing difficulty secondary to advanced dementia...I have inadequate oral intake r/t [related to] wt loss, fair appetite, AEB [as evidenced by] significant weight loss x 1, 3, and 6 months and variable intake at meals...I have continued to gradually lost weight d/t comorbidities [disease process] despite nutrition interventions." Interventions included assisting with eating and drinking as necessary, as well as monitoring for signs and symptoms of chewing, swallowing, or pocketing of food. R12 was to be offered a regular pureed diet with nectar thick liquids and in between meal supplementation. R18's care plan dated 11/14/14, showed, "I am at increased risk of dehydration r/t dependence on staff for feeding/drinking and thickened liquids diet order." Interventions directed staff to offer additional fluids, and to monitor for signs and symptoms of aspiration (inhalation of food or fluids causing pneumonia). R96's care plan dated 11/2/14, noted "I was often refusing meals which caused weight loss so I receive several supplements per day to help meet my nutrient needs. I had unavoidable weight loss r/t disease progression. I am not allowing staff to assist me during mealtime and am eating the majority of meals...." The goals included maintaining weight and interventions included staffs' assistance at mealtime. R103's care plan dated 5/2/14, noted, "I have	F 241		

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F 241	Continued From page 16 inadequate oral intake r/t dementia ABE intake records...I feed myself with set-up assist, but the staff cues and encourages me to eat. I have never been a big eater." Interventions included encouraging intake at meals. The director of nursing (DON) was interviewed on 5/13/15, at 10:46 a.m. The DON stated it was her expectation staff sat and had conversation with residents while assisting them to eat. The DON said it was "unacceptable" to stand over a resident while assisting them to eat. On 5/14/15, at 8:39 a.m. the DON explained R103 periodically needed assistance to eat. The facility's 8/13, Resident's Dining Room policy directed staff to "provide residents with a socializing atmosphere at mealtimes." A 1/14, Quality of Life--Dignity policy noted, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan 1 of 3 for residents (R39) reviewed for accidents. Findings include:	F 282	NA-C received immediate re-education regarding following all residents individualized plan of care. The policy and procedure for care planning was reviewed and remains current. Nursing staff will be re-educated by 6-23-15 on following each resident's individualized plan of care.	

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F 282	Continued From page 17 R39's care plan revised 12/15/14, directed staff as follows: "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. At 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was unable to recall." During an interview on 5/13/15, at 9:00 a.m. the DON reported R39 was known to self-transfer. At 9:05 a.m. the DON and RN-B were interviewed.	F 282	Random weekly audits will be conducted for 90 days on each unit to ensure staff provide care consistent with each residents care planned interventions. Audits will be reviewed by the Director of Nursing and/or designee and submitted to the monthly QAPI 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	

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F 282	Continued From page 18 RN-B reiterated that although she was not working at the time of R39's injury, it was reported to her that R39 stated at the time of the incident she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes." On 5/13/15, at 2:25 p.m. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. A policy for care plans was requested and not provided.	F 282		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	The vial of insulin for resident (R 16) was removed from the medication cart upon discovery. All medication carts were audited and all expired medications were removed on 5/11/15. The policy and procedure for medication storage was reviewed and remains current. Licensed nursing staff will be re-educated on the policy by 6-23-15. Facility consulting pharmacy will be completing med storage audits on all units the week of 6-15-15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 19 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure undated insulin was not stored for use for 1 of 3 residents (R16) on the transitional care unit (TCU) cart 2. In addition, the facility failed to remove expired stocked medications on the TCU cart 1 and 2 and the north-south cart on the long term care unit (LTC), potentially affecting the 34 residents on those units. Findings include: The facility's medication storage system was observed on the TCU and LTC units on 5/11/15, at 1:00 p.m. R16's Novolog mix 70/30 was stored at room temperature and lacked a written opened date; the last refill date was 3/23/15. In addition, medication storage carts 1, 2 and north-south carts on the TCU and LTC contained for following expired stocked medications stored for use:	F 431	Random weekly audits will be conducted for 90 days on each nursing unit to ensure medications are stored properly according to facility policy and procedure. Audits will be reviewed by the Director of Nursing and/or designee and submitted to the monthly QAPI 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	

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F 431	Continued From page 20 1) two bottles of aspirin (for pain, fever, inflammation) 325 milligrams (mg) one with an opened date of 1/20/15, and expiration date of 11/20/14, and the second with an expiration date of 4/15; 2) folic acid (to produce and maintain new cells) 0.4 mg with an opened date of 6/1/14, and expiration date of 3/15; 3) cranberry pills (prevent urinary tract infections) 450 mg with on opened date of 12/16/14, and expiration date of 6/14; 4) geri-lanta (for heartburn/indigestion) with an opened date of 2/4/15, and expiration date of 11/14; 5) ultratuss expectorant (for cough) with an opened date of 1/12/15, and expiration date of 3/15; 6) calcium 500 mg with an opened date of 3/6/15, and expiration date of 3/15; and 7) zinc sulfate (mineral supplement) with an opened date of 6/26/14, and expiration date of 9/14. R16's physician orders dated 4/30/15, indicated the resident's insulin use was to be monitored and documented. R16's 5/15 medication administration record (MAR) directed staff to administer Novolog mix 70/30 suspension injection subcutaneous of 30 units daily at 7:30 a.m. and 10 units daily at 5:30 p.m. During an interview on 5/11/15, at 1:00 p.m. a licensed practical nurse (LPN)-B confirmed the undated insulin for R16 had been stored for use at room temperature on cart 2, and lacked an opened date. LPN-B confirmed the expired stocked medication on cart 1 and 2 had expired and should have been removed from the cart and placed in the storage room for destruction.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 21 During an interview on 5/11/15, at 1:29 p.m. the director of nursing (DON) verified R16's insulin lacked an opened date and the stocked house medications were indeed expired. The DON explained that staff was to check medications for expiration dates, date insulins with opened and expiration dates, remove any expired medications from the medication carts, and place the items in the storage room for destruction. The DON stated that Novolog mix 70/30 was viable for 28 days once opened. A registered nurse (RN)-B verified in an interview on 5/11/15, at approximately 1:45 p.m. that the house stock medication on the north-south cart shown to her had expired. RN-B explained that the expired medications should have been removed from the medication cart for destruction. The facility's 7/13, Medications: Storage of policy indicated "no discontinued, outdated or deteriorated medications are available for use in this facility. All such medications are destroyed." The manufacturer's package insert for Novolog mix 70/30 noted insulin should have been destroyed after 28 days, even if insulin remained in the vial or pens.	F 431		

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	245067	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/12/2015

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St 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 (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok JB 6-15-15 RECEIVED JUN 10 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6/3/15

EXIT: 5/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6-9-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Lucas Care Center was constructed at 5 different times.. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor are used for health care). In 1960 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and the 4 additions and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a	K 000		

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	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/12/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	**500 SOUTHEAST FIRST STREET** **FARIBAULT, MN 55021**

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K 000	Continued From page 2 fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: This Standard is not met as evidence by: Based on observation and staff interview, the	K 017		

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K 017	Continued From page 3 facility failed to provide corridor wall separation in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6, 19.3.6.1, 19.3.6.2.1 and 19.3.6.2.2 . The deficient practice could affect 30 out of 68 residents. Findings include: On facility tour between 9:15 AM and 12:30 PM on 05/12/2015, observation revealed in the 1990 addition that there are penetrations above the ceiling around beams, sprinkler lines and cabling. The building is fully sprinkled, however, there are open grate ceiling tiles that do not limit the transfer of smoke. This deficient practice was confirmed by the Facility Maintenance Director (DM) at the time of discovery.	K 017	The roof top unit for the 1990 building addition will have ducted returns installed and the 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/or designee Date of Completion: 6-23-15	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide reliable lighting for all components of the means of egress as required by 2000 NFPA 101, Section 19..2.9.1, 7.8, and 7.9. The deficient practice could affect 20 out of 68 residents.	K 045	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	

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K 045	Continued From page 4 Findings include: On facility tour between 9:15 AM and 12:30 PM on 05/12/2015, observation revealed, that the lower level - SW exit discharge does not have a two bulb fixture on the exterior of building. NOTE: Check ALL exterior lights for this deficiency This deficient practice was confirmed by the Facility Maintenance Director (DM) at the time of discovery.	K 045		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility used portable space heaters in non-resident care areas and failed to have a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101-2000 edition, Section 19.7.8. This deficient practice could affect all patients, visitors and staff. Findings include: On facility tour between 9:15 AM and 12:30 PM	K 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	

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ST LUCAS CARE CENTER	**500 SOUTHEAST FIRST STREET** **FARIBAULT, MN 55021**

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K 070	Continued From page 5 on 05/12/2015, observation revealed that the Lower Level - office area, had 1 portable space heater not plugged in and 1 was that was plugged in, but the facility did not have written policies addressing where in the facility the space heater may be used or how the space heater was evaluated to assure that they meet the requirements of NFPA 101-2000 edition, Section 19.7.8. This deficient practice was confirmed by the Facility Maintenance Director (DM) at the time of discovery.	K 070		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1 and 6.4.2. The deficient practice could affect all 68 residents. Findings include:	K 144		

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K 144	Continued From page 6 On facility tour between 9:15 AM and 12:30 PM on 05/12/2015, documentation review of the emergency generator revealed the following: 1. Transfer time was not recorded 2. The Facility Maintenance Director (DM) confirmed that the facility did not have a letter for the reliable fuel source for the natural gas emergency generator. The letter needs to contain all five points as required below: a. A statement of reasonable reliability of the natural gas delivery b. A brief description that supports the statement regarding the reliability c. A statement that there is a low probability of interruption of the natural gas d. A brief description that supports the statement regarding the low probability of interruption e. The signature of technical personnel from the natural gas vendor. 3. The 2 hour load bank test was not run at (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) These deficient practices were confirmed by the Facility Maintenance Director (DM) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 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	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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.

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 Meath

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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00571	A. BUILDING: _____ B. WING _____	05/14/2015

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ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 11-14, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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	00571	A. BUILDING: _____ B. WING _____	05/14/2015

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, MN 55164-0900	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2 by: Based on observation, interview and document review, the facility failed to follow the care plan 1 of 3 for residents (R39) reviewed for accidents. Findings include: R39's care plan revised 12/15/14, directed staff as follows: "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. At 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was	2 565		

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2 565	Continued From page 3 unable to recall." During an interview on 5/13/15, at 9:00 a.m. the DON reported R39 was known to self-transfer. At 9:05 a.m. the DON and RN-B were interviewed. RN-B reiterated that although she was not working at the time of R39's injury, it was reported to her that R39 stated at the time of the incident she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes." On 5/13/15, at 2:25 p.m. NA-C said two staff persons were supposed to transfer the resident, but said "some staff" transferred the resident with only one person. A policy for care plans was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. A system for educating appropriate staff and for monitoring could be developed. The quality committee could review to ensure the plan is sustained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive	21565		

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resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure self-administration of medication assessment was completed for 1 of 1 resident (R151) who received medication from the nurse without supervision of administration and/or had medication left at bedside.

Findings include:

R151 was observed in her room on 5/12/15, at 8:18 a.m. A pill cup, half full of medications and glass of water were on the resident's bedside table. R151 explained she took the medications after eating breakfast, and she was waiting for her breakfast to arrive. R151 stated, "I don't know what kind of pills are these, but I take pills every morning."

R151 was newly admitted to the facility on 5/6/15, and did not have Minimum Data Set completed at the time of the observation. The electronic medical record identified R151's diagnoses to include memory loss and unspecified glaucoma (loss of vision).

R151's unsigned physician's orders dated 5/6/15, did not direct the staff to leave the medications at the bedside. Orders included: fish oil capsule (dietary supplement) 1000 mg (milligrams) 2 capsules daily, furosemide (to remove excess fluid from the tissues) 40 mg daily, lansoprazole 30 mg daily, Lisinopril (to lower blood pressure)

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40 mg daily, potassium chloride extended release (for potassium deficiency) 20 mili-equivalent (MEQ) daily, calcium-vitamin D 500-200 mg-unit 1 tablet twice daily, docusate sodium (for constipation) 100 mg twice daily, ferrous sulfate (for iron deficiency anemia) 325 mg twice daily, metoprolol tartrate (for chest pain or to lower blood pressure) 50 mg by mouth twice daily, and gabapentin (for seizure disorder) 300 mg three times daily. All medications were scheduled in the medication administration record to be administered at 8:00 a.m.

R151's medical record lacked an assessment to determine whether the resident could safely self-administer medication (SAM). The care plan for R151 dated 5/6/15, did not address R151's ability to self-administer medications.

On 5/12/15, at 8:22 a.m. director of nursing (DON) verified a SAM assessment had not yet been completed for R151. The DON then entered R151's room, took the cup of pills from R151's bedside table and returned it to the licensed practical nurse (LPN)-A.

On 5/12/15, at 8:25 a.m. LPN-A stated she was not supposed to have left medications with R151 without confirming she had a SAM assessment in place. LPN-A explained R151 wanted to take her medications after breakfast, so they were left on the bedside table.

The DON then confirmed at 8:26 a.m. R151 did not have a SAM assessment completed and stated she expected the nurses to supervise and ensure residents were taking medications per the facility's policy.

The facility's 8/13, Self-Administration of

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21565	Continued From page 6 Medications policy directed staff to: "Upon admission, nursing will ask each resident if they would like to self-administer medications. If the resident has expressed a desire to self-administer, the interdisciplinary team will assess the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require that drugs be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make an assessment or until the care plan is completed within seven days upon completion of the comprehensive assessment...Nursing to get an order from the physician for self-administration of medications. Documentation of the ability to self-administer medications will appear on the resident's care plan." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure all residents who desire SAM are comprehensively assessed as capable of doing so. Nursing staff responsible for administering medications could be re-educated regarding ensuring a resident has been assessed as capable of SAM prior to leaving a resident unsupervised with medications. Periodic observations and audits could be conducted of medical records for appropriate assessments. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		

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21620	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure undated insulin was not stored for use for 1 of 3 residents (R16) on the transitional care unit (TCU) cart 2. In addition, the facility failed to remove expired stocked medications on the TCU cart 1 and 2 and the north-south cart on the long term care unit (LTC), potentially affecting the 34 residents on those units. Findings include: The facility's medication storage system was observed on the TCU and LTC units on 5/11/15, at 1:00 p.m. R16's Novolog mix 70/30 was stored at room temperature and lacked a written opened date; the last refill date was 3/23/15. In addition, medication storage carts 1, 2 and north-south carts on the TCU and LTC contained for following expired stocked medications stored for use: 1) two bottles of aspirin (for pain, fever, inflammation) 325 milligrams (mg) one with an opened date of 1/20/15, and expiration date of 11/20/14, and the second with an expiration date of 4/15; 2) folic acid (to produce and maintain new cells) 0.4 mg with an opened date of 6/1/14, and expiration date of 3/15; 3) cranberry pills (prevent urinary tract infections) 450 mg with on opened date of 12/16/14, and expiration date of 6/14; 4) geri-lanta (for heartburn/indigestion) with an opened date of 2/4/15, and expiration date of 11/14; 5) ultratuss expectorant (for cough) with an opened date of 1/12/15, and expiration date of	21620		

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21620	Continued From page 8 3/15; 6) calcium 500 mg with an opened date of 3/6/15, and expiration date of 3/15; and 7) zinc sulfate (mineral supplement) with an opened date of 6/26/14, and expiration date of 9/14. R16's physician orders dated 4/30/15, indicated the resident's insulin use was to be monitored and documented. R16's 5/15 medication administration record (MAR) directed staff to administer Novolog mix 70/30 suspension injection subcutaneous of 30 units daily at 7:30 a.m. and 10 units daily at 5:30 p.m. During an interview on 5/11/15, at 1:00 p.m. a licensed practical nurse (LPN)-B confirmed the undated insulin for R16 had been stored for use at room temperature on cart 2, and lacked an opened date. LPN-B confirmed the expired stocked medication on cart 1 and 2 had expired and should have been removed from the cart and placed in the storage room for destruction. During an interview on 5/11/15, at 1:29 p.m. the director of nursing (DON) verified R16's insulin lacked an opened date and the stocked house medications were indeed expired. The DON explained that staff was to check medications for expiration dates, date insulins with opened and expiration dates, remove any expired medications from the medication carts, and place the items in the storage room for destruction. The DON stated that Novolog mix 70/30 was viable for 28 days once opened. A registered nurse (RN)-B verified in an interview on 5/11/15, at approximately 1:45 p.m. that the house stock medication on the north-south cart shown to her had expired. RN-B explained that	21620		

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21620	Continued From page 9 the expired medications should have been removed from the medication cart for destruction. The facility's 7/13, Medications: Storage of policy indicated "no discontinued, outdated or deteriorated medications are available for use in this facility. All such medications are destroyed." The manufacturer's package insert for Novolog mix 70/30 noted insulin should have been destroyed after 28 days, even if insulin remained in the vial or pens. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) with the consulting pharmacist ensure policies adequately address medication storage. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21805		

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review, the facility failed to provide dignified dining assistance for 4 of 4 residents (R12, R18, R96, R103), who were dependent on staff assistance for eating.

Findings include:

The evening meal service was observed on 5/11/15, from 6:00 to 6:41 p.m. Four residents, R12, R18, R96, and R103 were seated at the same table. A nursing assistant (NA)-A and a registered nurse (RN)-A each assisted two residents with their meal. Both staff stood while feeding the residents throughout the entire meal. NA-A fed R96 and R18, and RN-A fed R103 and R12. R12 intermittently coughed/choked on food and fluids throughout the meal. Both staff turned their back to the first resident while assisting the second, and then turned their back toward the second while assisting the first, and so on.

At the end of the meal at 6:41 p.m. RN-A and NA-A both explained they did not normally work on the unit, but were "filling in" that shift. RN-A and NA-A each stated they normally stood between two residents while assisting them to eat.

NA-B was interviewed on 5/11/15, at 6:50 p.m. NA-B sat while feeding one resident and encouraging another resident to eat. NA-B stated normally staff sat beside a resident while assisting with eating, however, RN-A and NA-A were "new."

The following day at 8:36 a.m. R12, R18, R96, and R103 were again seated at a table together and were assisted to eat their breakfast. RN-C stood while periodically assisting residents with bites of food. Additionally, RN-C left the table and

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returned several times to complete other tasks such as obtaining juice for a resident, etc. RN-C explained it was easier for her to monitor the residents to ensure they did not leave the dining room during the meal if she stood while assisting them to eat.

Following breakfast at 8:50 a.m. R103 was asked about breakfast, however, he was unable to answer any questions.

R12's care plan dated 2/8/13, revealed, I have chewing difficulty secondary to advanced dementia...I have inadequate oral intake r/t [related to] wt loss, fair appetite, AEB [as evidenced by] significant weight loss x 1, 3, and 6 months and variable intake at meals...I have continued to gradually lost weight d/t comorbidities [disease process] despite nutrition interventions." Interventions included assisting with eating and drinking as necessary, as well as monitoring for signs and symptoms of chewing, swallowing, or pocketing of food. R12 was to be offered a regular pureed diet with nectar thick liquids and in between meal supplementation.

R18's care plan dated 11/14/14, showed, "I am at increased risk of dehydration r/t dependence on staff for feeding/drinking and thickened liquids diet order." Interventions directed staff to offer additional fluids, and to monitor for signs and symptoms of aspiration (inhalation of food or fluids causing pneumonia).

R96's care plan dated 11/2/14, noted "I was often refusing meals which caused weight loss so I receive several supplements per day to help meet my nutrient needs. I had unavoidable weight loss r/t disease progression. I am not allowing staff to assist me during mealtime and am eating the

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21805	Continued From page 12 majority of meals...." The goals included maintaining weight and interventions included staffs' assistance at mealtime. R103's care plan dated 5/2/14, noted, "I have inadequate oral intake r/t dementia ABE intake records...I feed myself with set-up assist, but the staff cues and encourages me to eat. I have never been a big eater." Interventions included encouraging intake at meals. The director of nursing (DON) was interviewed on 5/13/15, at 10:46 a.m. The DON stated it was her expectation staff sat and had conversation with residents while assisting them to eat. The DON said it was "unacceptable" to stand over a resident while assisting them to eat. On 5/14/15, at 8:39 a.m. the DON explained R103 periodically needed assistance to eat. The facility's 8/13, Resident's Dining Room policy directed staff to "provide residents with a socializing atmosphere at mealtimes." A 1/14, Quality of Life--Dignity policy noted, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality." SUGGESTED METHOD OF CORRECTION: The director of nursing with the social service designee could ensure polices and procedures reflect the provision of dignified care and services for all residents. Employees could be re-educated on these policies. Dining room audits could be conducted to ensure residents are assisted with meals in a safe and dignified manner, with the results of the audits brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen	21805		

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21805	Continued From page 13 (14) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to complete an thorough investigation to rule out potential neglect of care for 1 of 1 resident (R39) who sustained a fracture of unknown origin. Findings include: R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. An attempt to interview the resident was unsuccessful.	21990		

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	00571	A. BUILDING: _____ B. WING _____	05/14/2015

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ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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21990	Continued From page 14 On 5/11/15, at 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. The care plan for R39 revised 12/15/14, indicated "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39's quarterly Minimum Data Set (MDS) dated 3/6/15, revealed diagnoses including dementia and stroke. R39 was cognitively impaired and required extensive assistance for activities of daily living (ADLs) such as transfers, locomotion on and off the unit, dressing and toileting. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was unable to recall. The director of nursing [DON]	21990		

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21990	Continued From page 15 notified via notebook. Family will be called today at appropriate time due to no serious injury." The facility's internal investigation revealed staff who were interviewed reported they had either not cared for the resident, had no knowledge as to how the injury occurred, and/or had not noticed the resident was injured. The facility's investigative interviews were all dated 4/15/15. The interviews lacked information as to even approximate times the various staff cared for R39. In addition, none of the staff verified who had provided cares such as toileting and assisting the resident to bed on 4/14/15. The interviews were as follows: 1) NA-C reported, "She took the resident to the bathroom, but didn't see any swelling to ankle and was able to bear weight. States she didn't transfer to bed." 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." 3) NA-A's reported interview read, "[R39] couldn't bear weight and he noted her right ankle was swollen and he let the [TMA-A] know." 4) TMA-A's interview showed, "She informed the nurse and the nurse elevated the leg." During an interview on 5/13/15, at 9:00 a.m. the DON reported she was unaware R39 had reported her foot was caught in the bed. The DON stated R39 was known to self-transfer. At 9:05 a.m. the DON and RN-B were interviewed. RN-B reiterated that although she was not working at the time of R39's injury, it was reported to her that R39 stated at the time of the incident	21990		

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21990	Continued From page 16	21990		

she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes."

On 5/13/15, at 9:15 a.m. the DON reviewed the incident report submitted to the designated State agency (SA) which read, "On 4/14/15, [R39] was transferred and [NA-A] noted that resident had difficulty standing and right leg gave out. [LPN-C] noted that area was swollen and not bruise [sic]. On 4/15/15, area assessed again and x-ray [sic]. X-ray resulted in non-displaced fracture lateral malleolus inferiorly. [R39] stated it was twisted on transfers...Staff had given her a shower and skin assessment was done but on 4/14/15 evening shift around 1930 [7:30 p.m.] it was noted. [R39] does self transfers and self propels down the hallway to meals and activities. It is also possible that she could have hit ankle against something causing the break...Staff are made aware of the plan of care by care plan, care data sheets, the communication book, nursing report, and the medical record."

On 5/13/15, at 2:25 p.m. NA-C verified she had worked with R39 the evening shift on 4/14/15. NA-C reported she had "only" walked into R39's room to stand her up in her chair and check for incontinence, and then assisted her to sit back down. She denied transferring the resident to the bathroom and again stated she "just stood her up" and checked her prior to the evening meal. NA-C did not know who took escorted R39 to the dining room, or who had assisted the resident to use the toilet that evening shift. NA-C was shown a sheet identifying her as the person responsible

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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, etc...The facility identify the staff member responsible for...investigation of the event and implements immediate changes to keep the resident safe; with follow 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 findings...The 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 policy and procedures to prevent further	21990		

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21990	Continued From page 18 occurrences." Signs of potential neglect requiring investigation included fractures. The policy also noted "Each and every incident will have an internal investigation...All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident." 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 CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.	22000		

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22000	Continued From page 19 (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	22000		

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22000	Continued From page 20 review, the facility failed to follow their policy for conducting a thorough investigation into potential neglect of care for 1 of 1 resident (R39) who sustained a fracture of unknown origin. Findings include: 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 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 findings...The 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 policy and procedures to prevent further occurrences." Signs of potential neglect requiring investigation included fractures. The policy also noted "Each and every incident will have an internal investigation...All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident."	22000		

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22000	Continued From page 21 R39 was observed lying in bed on 5/11/15, at 2:00 p.m. The resident had a cast on her right foot. At 5/11/15, at 2:41 p.m. a registered nurse (RN)-B explained the resident had "a fractured ankle that occurred on the evening shift on 4/14/15." Although RN-B did not work the evening of 4/14/15, she had received a report the following day that R39 got her foot caught under the bed during a transfer. RN-B reported she did not, however, know any specific details of the incident, such as what staff were involved or when exactly the resident sustained the injury. The care plan for R39 revised 12/15/14, indicated "The resident is to have assistance of two staff with ambulation and transfers, needs two staff to transfer to/from toilet as she requests." On 3/11/15, an addition was made to the care plan that read, "assist of 2 for transfers to prevent falls." R39's quarterly Minimum Data Set (MDS) dated 3/6/15, revealed diagnoses including dementia and stroke. R39 was cognitively impaired and required extensive assistance for activities of daily living (ADLs) such as transfers, locomotion on and off the unit, dressing and toileting. A progress note dated 4/15/15, at 6:37 a.m. read, "Licensed practical nurse [LPN-C] was informed from the trained medication assistant [TMA-A], they noted resident had difficulty standing; right leg gave in as she stood. Right ankle was swollen. Assessed right ankle, swelling noted all around to right ankle. No bruising noted. Tender to touch. When asked resident what happened, resident stated, 'It got caught under the bed' per [TMA-A]. The resident stated, 'She put it on wrong, it hurts.' The nurse [LPN-C] asked her what that statement meant and the resident was	22000		

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22000	Continued From page 22	22000		

unable to recall. The director of nursing [DON] notified via notebook. Family will be called today at appropriate time due to no serious injury."

The facility's internal investigation revealed staff who were interviewed reported they had either not cared for the resident, had no knowledge as to how the injury occurred, and/or had not noticed the resident was injured. The facility's investigative interviews were all dated 4/15/15. The interviews lacked information as to even approximate times the various staff cared for R39. In addition, none of the staff verified who had provided cares such as toileting and assisting the resident to bed on 4/14/15. The interviews were as follows:

1) NA-C reported, "She took the resident to the bathroom, but didn't see any swelling to ankle and was able to bear weight. States she didn't transfer to bed."

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."

3) NA-A's reported interview read, "[R39] couldn't bear weight and he noted her right ankle was swollen and he let the [TMA-A] know."

4) TMA-A's interview showed, "She informed the nurse and the nurse elevated the leg."

During an interview on 5/13/15, at 9:00 a.m. the DON reported she was unaware R39 had reported her foot was caught in the bed. The DON stated R39 was known to self-transfer. At 9:05 a.m. the DON and RN-B were interviewed. RN-B reiterated that although she was not working at the time of R39's injury, it was reported

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22000	Continued From page 23	22000		

to her that R39 stated at the time of the incident she got "her 'foot caught' in the bed." At 9:25 a.m. the DON reported she did not know who had cared for the resident at the time of the incident, and was unaware the care plan and the NA care sheets directed staff to use a two person transfer for R39. When asked if one person had transferred the resident the DON replied, "Yes."

On 5/13/15, at 9:15 a.m. the DON reviewed the incident report submitted to the designated State agency (SA) which read, "On 4/14/15, [R39] was transferred and [NA-A] noted that resident had difficulty standing and right leg gave out. [LPN-C] noted that area was swollen and not bruise [sic]. On 4/15/15, area assessed again and x-ray [sic]. X-ray resulted in non-displaced fracture lateral malleolus inferiorly. [R39] stated it was twisted on transfers...Staff had given her a shower and skin assessment was done but on 4/14/15 evening shift around 1930 [7:30 p.m.] it was noted. [R39] does self transfers and self propels down the hallway to meals and activities. It is also possible that she could have hit ankle against something causing the break...Staff are made aware of the plan of care by care plan, care data sheets, the communication book, nursing report, and the medical record."

On 5/13/15, at 2:25 p.m. NA-C verified she had worked with R39 the evening shift on 4/14/15. NA-C reported she had "only" walked into R39's room to stand her up in her chair and check for incontinence, and then assisted her to sit back down. She denied transferring the resident to the bathroom and again stated she "just stood her up" and checked her prior to the evening meal. NA-C did not know who took escorted R39 to the dining room, or who had assisted the resident to use the toilet that evening shift. NA-C was shown

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22000	Continued From page 24 a sheet identifying her as the person responsible 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. SUGGESTED METHOD OF CORRECTION: The social service designee with the director of nursing could ensure facility policies were followed regarding investigating all injuries of unknown origin for 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 CORRECTION: Fourteen (14) days.	22000		