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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 8TQI
Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**

2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Whitlock, HFE NEII 02/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/12/2014
(L33)

DETERMINATION APPROVAL

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

CCN-24-5338

A Post Certification Revisit was completed by the Departmnts of Public Safety to verify correction of deficiencies issued pursuant to the standard survey completed December 5, 2013. The results of the revisit determined correction, effective January 31, 2014. The facility requested a temporary waiver for deficiency cited at K38 with a completion date of April 29, 2014. In addition, the facility requested an annual waiver for deficiency cited at K67, documentation supporting the waiver had previous been sent to CMS with recommendations to approve.

Effective January 31, 2014, the facility is certified for 170 skilled nursing facility beds.

CMS Certification Number (CCN): 24-5338

April 9, 2014

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

Dear Mr. Spates:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 31, 2014 the above facility is certified for:

170 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

Your request for a temporary waiver of K38 has been approved based on the submitted documentation.

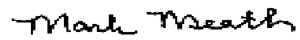
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any questions.

Sincerely,



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

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2014

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

RE: Project Number S5338024

Dear Mr. Spates:

On December 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for the standard survey completed on December5, 2013. 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)

On January 24, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 3, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, effective January 31, 2014 and therefore remedies outlined in our letter to you dated December 16, 2013, will not be imposed.

Correction of the Life Safety Code deficiency cited under K38 and at the time of the December 5, 2013 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of April 29, 2014, has been approved. Your request for a continuing waiver involving the deficiency cited under K67 at the time of the December 5, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245338	A. Building B. Wing	1/24/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/14/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/14/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/14/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KS/KFD	Date: 2/28/2014	Signature of Surveyor: 28588	Date: 1/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/5/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

AH Form Approved
2/5/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00138	A. Building B. Wing	1/24/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	01/14/2014	ID Prefix 21015 Reg. # MN Rule 4658.0610 Subp. 7 LSC	01/14/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KFD	2/28/2014	28588	1/24/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/5/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245338	01 - MAIN BUILDING 01	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	12/27/2013	ID Prefix Reg. # NFPA 101 LSC K0052	01/31/2014	ID Prefix Reg. # NFPA 101 LSC K0062	12/04/2013
ID Prefix Reg. # NFPA 101 LSC K0071	12/06/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KS/KJ	Date: 2/28/2014	Signature of Surveyor: 25822	Date: 2/3/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
12/4/2013	YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2014

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

Re: Enclosed Reinspection Results - Project Number S5338024

Dear Mr. Spates:

On January 24, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 16, 2013 with orders received by you on December 23, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

ID: 8TQI
Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245338**
2. STATE VENDOR OR MEDICAID NO. (L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/05/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, **02 SNF/NF/Dual**, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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

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

12. Total Facility Beds **170** (L18)

13. Total Certified Beds **170** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 01/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/03/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN-245338

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. In addition, at the time of the December 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5338020 that was found to be unsubstantiated.

Documentation supporting the facility's request for a temporary waiver with a completion date of April 30, 2014, has been approved. The facility's request for a continuing waiver involving the deficiency cited at K067 and a temporary waiver involving the deficiency cited at K038. Approval of the waiver requests was recommended. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3759

December 16, 2013

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

RE: Project Number S5338024, H5338020

Dear Mr. Spates:

On December 5, 2013, 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. In addition, at the time of the December 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5338020.

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. In addition, at the time of the December 5, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5338020 that was found to be unsubstantiated.

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Kathyrn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529

Telephone: (507) 537-7158
Fax: (507) 344-2723

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 January 14, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 14, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 5, 2014 (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 June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5338s14.rtf

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING ____ B. WING ____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint H5338020 had not been substantiated during this survey.	F 000	RECEIVED JAN 03 2014 Minnesota Department of Health Marshall approved 1/6/14 KMf	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to make the most recent survey results available and readily accessible to	F 167	**F 167** 1.The notice of survey results is posted on the bulletin board at the main entrance of the nursing home. The notice states where the survey results are posted. 2. The print was enlarged and the notice was posted at the bottom of the bulletin board. This will enable residents in wheelchairs to read the notice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot D. Spates — TITLE: CEO & Administrator — (X6) DATE: 12-31-13

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 167	Continued From page 1 the 162 residents who reside in the facility and/or their visitors. Findings include: The state survey results were unavailable for residents and/or visitors to examine without having to ask for staffs' assistance. During an initial tour of the first and second floor of the facility on 12/02/13, at 1:35 p.m. the surveyor was unable to locate the State survey results, or information where the results could be located. Upon request, a social worker (SW)-A located a black three-ring-binder on a book case in the Four Corners sitting area on the first floor. The book case was located in a corner behind a chair, and the three-ring-binder was filed on a bottom shelf of the book case. Multiple binders and books were noted to be placed on either side of it. SW-A stated, "There should be a sign here that tells where they are." SW-A was unable to locate the sign, however, and then stated, "There is a note by the chapel that tells where they are." A glass-enclosed case located on a wall by the chapel entrance contained multiple written notices. Above the Resident Bill of Rights poster a folded 8 1/2 x 11 inch piece of paper approximately six feet from the floor noted "State survey results could be located in the Four Corners area". The SW verified persons in a wheelchair would have had difficulty viewing the notice. During an interview on 12/4/13 at 1:50 p.m., the director of nursing also acknowledged the most recent survey results were not easily accessible to either residents and/or their visitors.	F 167	3. The notice was revised to state that survey results can be found in white three-ring binders in two locations. (1) The literature rack outside the Chaplain's Office on 1st Floor and, (2) The entertainment center in the lounge area adjacent to the 2nd North Dining Room. 4.The Survey Results are located in white three-ring binders, and are clearly labeled and easily accessible to residents in wheelchairs. 5. Completion date is January 14, 2014. The Social Services Director will be responsible for monitoring the availability of the survey results.	

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JAN 03 2014
Minnesota Department of Health
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F 280	Continued From page 2	F 280	**F280**	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan for 1 of 3 residents (R84) reviewed for pressure ulcers and for 1 of 1 resident (R30) who received dialysis. Findings include: R84's care plan (dated 10/14/13) identified a risk for alteration skin integrity related to bruising and skin tears, however, the plan failed to address an existing pressure ulcer on the left heel and	F 280	1. R84 care plan for pressure ulcers was reviewed and revised by the Nurse Manager. R80 care plan for dialysis was reviewed and revised by the Nurse Manager . 2. Care plans for residents receiving dialysis have been reviewed and revised regarding access sites and interventions. Care plans for residents with pressure ulcers have been reviewed and revised to include site and interventions. Nurse Managers are responsible for developing the care plans. 3. Licensed nurses have been educated by the RN Staff Education Nurse on appropriate care planning of dialysis and pressure ulcers.	

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F 280	Continued From page 3 relevant interventions used to treat the ulcer. Wound care for R84 was observed on 12/4/13, at 10:20 a.m. The resident had a soft bolster and soft foam boot applied to the foot. In addition, treatment was administered to the pressure ulcer, the wound was measured, and a dressing was applied. The following day (12/5/13) at 7:15 a.m. R84 was observed with legs and feet elevated on a foam wedge, in addition, to the soft foam boot on the left foot. A wound assessment dated 12/4/13 noted the resident's decline in condition, weight loss, left heel pressure ulcer measuring 0.3 cm x 0.7 cm, with eschar, and no signs of infection. Some of the interventions identified on the assessment included protein supplement, mattress and chair cushion. On 12/5/13, at 10:30 a.m. a registered nurse (RN)-A was interviewed regarding missing information on R84's care plan which had identified the presence of the pressure ulcer, as well as relevant interventions to promote healing. The RN verified the care plan was incomplete and did not address any treatment, the soft foam boot, the use of the wedge which elevated the heels nor the protein supplement. R30 was receiving dialysis, however, the care plan (dated 10/7/13) lacked relevant information regarding dialysis care, including identification of the correct access site. The care plan was not revised to reflect current interventions. R30's care plan dated 10/7/13 identified dialysis related to renal failure, with a vascular access right chest/fluid restriction. "Site right upper	F 280	4. Random audits of care plans for residents with pressure ulcers or residents receiving dialysis will be completed by the Nurse Manager, results will be reviewed at the next QA meeting, and then quarterly thereafter by the Nurse Manager. 5. Education will be completed by Jan 14, 2014 and reviewed at the next QA meeting. Audits will be completed by the Nurse Manager and will be ongoing.	

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F 280	Continued From page 4 chest." Interventions included physician orders for bleeding and assess access site and bruit (listening for abnormal sounds) daily. On 12/4/13, at 1:58 p.m. a registered nurse (RN)-B was interviewed regarding R30's dialysis port, and the RN clarified the resident had an access port in the arm. On 12/4/13, at 2:15 p.m. RN-B was interviewed regarding the dialysis site assessment and monitoring. She stated they had not been documenting the bruit assessment checks. On 12/5/13, at 8:45 a.m. RN-C explained that R30 had a fistula placed in the left arm on 4/12/13. The previous port in the chest was left in place and had been used for dialysis until 8/13. The RN verified the correct access site should have been identified on the care plan and verified it had not been updated to reflect the current status.	F 280		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	**F 371** 1. All dietary staff will be re-educated by January 14, 2014 on the proper drying and storing of kitchen utensils. This will be randomly audited by the Dietary Manager to ensure compliance is being met.	

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F 371	Continued From page 5 Based on observation, interview and document review, the facility failed to store pots and pans in a clean and sanitary manner which had the potential to affect the 162 residents who were served food from the kitchen. Findings include: During an initial kitchen tour with the registered dietitian (RD) on 12/2/13, at 1:50 p.m. the following was observed and was verified by the RD at the time: (1) A random selection of six square pans ready for use were stored wet with water droplets on the inner and outer sides of the pans; (2) A fan above the clean dish area had dirty blades and was running on the high speed; and (3) The tile (4.5 x 4.5 inches in size) wall and stainless steel backsplash on the clean side of the dishwasher was covered in a greasy film that was three tiles high and 17 tiles across. According to the RD on 12/5/13, at 9:54 a.m., the night shift staff was responsible for cleaning the backsplash area nightly. The Daily Cleaning Schedule was reviewed and directed night shift staff to wipe down the white wall and stainless steel on the clean side of the dishwasher.	F 371	2. Effective December 12, 2013, fans will be cleaned weekly and will be checked and cleaned, if needed, more often. This will be randomly audited by the Dietary Manager to ensure compliance is being met. 3. All staff will be re-educated by January 14, 2014 on following cleaning schedule and documenting completion of duties. This will be randomly audited by the Dietary Manager to ensure compliance is being met. 4. A dietary in-service is scheduled for January 7, 2014. The Registered Dietician and Dietary Manager are responsible for educating dietary staff on cleaning procedures.	

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

F5338022

PRINTED: 12/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey, St. Johns Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok w/TW for K38 w/AW for K67 PB 1-8-14 RECEIVED JAN - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 12-5-13 DC: 1-14-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot D. Spates — TITLE: CEO & Administrator — (X6) DATE: 1-2-2014

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Johns Lutheran Home building was constructed at 4 different times. The original building is a 3 story building and was constructed in 1960. It was determined to be of Type II(222) construction. In 1964, a 2 story addition was added to the northeast and southeast wings that was determined to be of Type II(222) construction. In 1967, a 2 story addition was constructed to the North and South that was determined to be of Type II(222) construction. In 1980, a 2 story addition was added to the South Annex and was determined to be Type II (111). Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as a Type II(111) building. The facility is fully sprinkled . The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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

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K 000	Continued From page 2 The facility has a capacity of 170 beds and had a census of 163 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 60 out of 162 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 12/04/2013, observation revealed that the following was found:	K 029	**K 29** 1. The door coordinator parts have been ordered. The parts will be installed as soon as they arrive, but no later than January 29, 2014. The Environmental Services Supervisor will monitor for completion. 2. Holes in the soiled utility room door were filled on 12-5-13. All inside doors were also inspected on 12-5-13 for compliance. 3. A door closer was installed on the storage room door on 12-27-13 4. The warehouse storage room penetrations were filled on 12-5-13. 5. The boiler room penetrations were filled on 12-5-13.	

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K 029	Continued From page 3 1. #116 - Storage/sewing room(over 50 sq ft) double door - does not have a door coordinator 2. #253 - soiled utility room door has holes that go all the way through 3. #104 - storage room (over 50 sq ft) no door closer 4. Basement - warehouse storage room - open penetrations around several pipes 5. Boiler room - open penetrations around several pipes These deficient practices were confirmed by the Director of Environmental Services (SS) at the time of discovery.	K 029	6. All outside contractors will be reminded that they are responsible to fill any penetrations which may occur from work they perform. 7. The Environmental Services Director will monitor for ongoing compliance.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect 60 out of 162 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 12/04/2013, observation revealed, that the concrete hard path from the south central exit	K 038	**K38** 1.The concrete will be replaced as soon as the weather allows, but no later than April 30, 2014. 2. The Environmental Services Director will monitor for ongoing compliance. 3. Due to the extreme weather conditions in Minnesota a waiver is being requested with a completion date on or before April 30,2014. The waiver is attached to the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE** **ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 4 discharge to the public way is breaking up, creating an uneven walking surface. This deficient practice was confirmed by the Director of Environmental Services (SS) at the time of discovery.	K 038		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.5.2, 19.3.6.1 and 9.6. The deficient practice could affect 60 out 162 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 12/04/2013, observation revealed, that the ice machine room # 1126 , now open to the corridor has no automatic smoke detector tied into the building fire alarm system.	K 052	**K52** 1.The smoke detector will be added to the ice machine room on or before Jan 31, 2014. 2. The Environmental Services Director will monitor for ongoing compliance.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING ___	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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K 052	Continued From page 5 This deficient practice was confirmed by the Director of Environmental Services (SS) at the time of discovery.	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1. This deficient practice could affect all 162 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 12/04/2013, the review of the annual fire sprinkler reports from Olympic Fire Protection indicated that the last documented annual sprinkler system inspection/test was done on 09/24/2013. This deficient practice was confirmed by the Director of Environmental Services (SS) at the time of discovery.	K 062	**K62** Sprinkler inspections 1.The 2013 sprinkler inspection was completed on 12-4-2013. 2.To insure that the inspections occur on time each year, a reminder has been placed on the calendar of the Environmental Services Director, and the Maintenance Coordinators computers. The Sprinkler inspector has also be notified. 3. The Environmental Services Director will monitor for ongoing compliance. K067	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 067	A waiver is being requested and is attached to the plan of correction.	

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	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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K 067	Continued From page 6 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		
	This STANDARD is not met as evidenced by: Based on observations and documentation review, the facility's general ventilating and air conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 162 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 12/04/2013, observation revealed, that the corridors in the 1960, 1964, and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous years. This deficient practice was confirmed by the Director of Environmental Services (SS) at the time of discovery.			
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens	K 071	K071 1.The domestic sprinkler head located on the second floor soiled linen chute was removed on 12-6-13.	

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	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/04/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 071	Continued From page 7 directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.	K 071	2. The Environmental Services Director will continue to monitor for compliance.	
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and 1999 NFPA 82 Section 3-2.5.. This deficient practice could affect 60 out 162 residents. Finding include: On facility tour between 8:30 AM and 12:30 PM on 12/04/2013, observation revealed, that the 2nd floor, soiled linen chute has a domestic sprinkler head at top of chute. There is another NFPA 13 fire sprinkler head with-in 6 inches of the domestic fire sprinkler head. This deficient practice was confirmed by the Director of Environmental Services (SS) at the			

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	245338	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/04/2013**

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K 071	Continued From page 8 time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 071		

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, January 08, 2014 2:25 PM
To:	'rochi_lsc@cms.hhs.gov'
Cc:	Schroeder, Gary (DPS); 'scotspates@stjohnsofalbertlea.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	St John's Lutheran Home (245338) K67 Annual Waiver Request

This is to inform you that St John's Lutheran Home is requesting an annual waiver for K67, corridors as a plenum. The exit date was 12-15-13.

I am recommending that CMS approve this waiver request.

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

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, January 08, 2014 2:18 PM
To:	'jan.suzuki@cms.hhs.gov'
Cc:	Schroeder, Gary (DPS); 'scotspates@stjohnsofalbertlea.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	St Johns Lutheran Home (235338) K38 Temporay Waiver Request

This is to inform you that I am accepting St John Lutheran Home's request for a temporary waiver until 4-30-14 for K38, for an outside path of egress. The exit date was 12-15-13.

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

Name of Facility St. John's Lutheran Home, Albert Lea, MN 56007 **2000 CODE**

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K038 Exit Access is arranged so that exits are readily accessible at all times.	A temporary waiver is being requested for K 038 due to extreme weather conditions in MN. A. Compliance with this provision will cause unreasonable hardship because: 1. Weather conditions are extreme in MN making it challenging to properly prepare and poor a new cement walkway during the winter months. B. There will be no adverse effect on the health and safety of the facility's residents and staff because: 1. Although the walkway needs to be replaced it is still usable. 2. The entire building is protected by a supervised automatic sprinkler system installed in accordance with NFPA 13. 3. The fire alarm system is an addressable system. 4. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. 5. Annual service and maintenance contracts are in place to insure that all of the fire protection systems are operational at all times. 6. The building fire alarm system is monitored to provide automatic fire department notification. 7. Fire safety training is provided to all employees on an annual basis and at orientation for new hires. 8. Fire drills are conducted at least quarterly on each shift.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	**Title**	**Office**	**Date**
[signature] Sheehan	Fire Safety Supervisor	State Fire Marshal	1-8-14

2000 CODE

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

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC section 9.2 and NFPA 90A, 1999 ED., because the corridors are being used as a plenum.	A waiver is being requested for K 067 A. Compliance will this provision will cause unreasonable hardship because: 1. The estimated cost of upgrading the facility's HVAC system to comply with NFPA 90A is $788,000. This estimate does not Include: electrical, roofing, ceiling modifications, and mechanical design fees. 2. The ceiling tiles that would need to be removed to install required ductwork contain asbestos. The cost of abatement is difficult to estimate. Moreover, this would cause a significant hardship for residents and staff during abatement. B. There will be no adverse effect on the health and safety of the facility's residents and staff because: 1. The entire building is protected by a supervised automatic sprinkler system installed in accordance with NFPA 13. 2. The fire alarm system is an addressable system. 3. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. 4. Annual service and maintenance contracts are in place to insure that all of the fire protection systems are operational at all times. 5. The building fire alarm system is monitored to provide automatic fire department notification. 6. Fire safety training is provided to all employees on an annual basis and at orientation for new hires. 7. Fire drills are conducted at least quarterly on each shift. See additional information attached.

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 1-8-14

Form CMS-2786R (02/04) Previous Versions Obsolete

K067 Continued

C. St. John's master plan includes replacing the existing nursing home within the next five to six years. Replacement of the existing nursing home would happen in two phases.

   1. St. John's has applied to the Minnesota Department of Health (MDH) to build a new 84-bed nursing home. The new nursing home will enable St. John's to relocate over 50% of the residents residing at the current facility to the new facility. Contingent upon approval from MDH, construction of the new facility would begin within the next 12 months. The new nursing home would comply with NFPA 90A.
   2. Phase two of the master plan includes building a second new nursing home within the next five to six years. All residents at the existing site would be relocated to the new nursing home. This building would also be built to comply with NFPA 90A.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: ______ B. WING ______	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 2, 3, 4 and 5th, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring; Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105; Mankato, Minnesota 56001	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.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal	2 570		

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2 570	Continued From page 2 guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the comprehensive care plan for 1 of 3 residents (R84) reviewed for pressure ulcers and for 1 of 1 resident (R30) who received dialysis. Findings include: R84's care plan (dated 10/14/13) identified a risk for alteration skin integrity related to bruising and skin tears, however, the plan failed to address an existing pressure ulcer on the left heel and relevant interventions used to treat the ulcer. Wound care for R84 was observed on 12/4/13, at 10:20 a.m. The resident had a soft bolster and soft foam boot applied to the foot. In addition, treatment was administered to the pressure ulcer, the wound was measured, and a dressing was applied. The following day (12/5/13) at 7:15 a.m. R84 was observed with legs and feet elevated on a foam wedge, in addition, to the soft foam boot on the left foot. A wound assessment dated 12/4/13 noted the resident's decline in condition, weight loss, left heel pressure ulcer measuring 0.3 cm x 0.7 cm, with eschar, and no signs of infection. Some of the interventions identified on the assessment included protein supplement, mattress and chair cushion.	2 570		

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2 570	Continued From page 3	2 570		

On 12/5/13, at 10:30 a.m. a registered nurse (RN)-A was interviewed regarding missing information on R84's care plan which had identified the presence of the pressure ulcer, as well as relevant interventions to promote healing. The RN verified the care plan was incomplete and did not address any treatment, the soft foam boot, the use of the wedge which elevated the heels nor the protein supplement.

R30 was receiving dialysis, however, the care plan (dated 10/7/13) lacked relevant information regarding dialysis care, including identification of the correct access site. The care plan was not revised to reflect current interventions.

R30's care plan dated 10/7/13 identified dialysis related to renal failure, with a vascular access right chest/fluid restriction. "Site right upper chest." Interventions included physician orders for bleeding and assess access site and bruit (listening for abnormal sounds) daily.

On 12/4/13, at 1:58 p.m. a registered nurse (RN)-B was interviewed regarding R30's dialysis port, and the RN clarified the resident had an access port in the arm.

On 12/4/13, at 2:15 p.m. RN-B was interviewed regarding the dialysis site assessment and monitoring. She stated they had not been documenting the bruit assessment checks.

On 12/5/13, at 8:45 a.m. RN-C explained that R30 had a fistula placed in the left arm on 4/12/13. The previous port in the chest was left in place and was being used for dialysis until 8/13. The RN verified the staff should have been monitoring the bruit and access site, however, no documentation to that effect was evident nor

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2 570	Continued From page 4 provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could re-educate staff regarding following resident care plans as determined by their care needs and should be updated to reflect the current status of each resident. A monitoring program could be established in order to assure care plans are followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to store pots and pans in a clean and sanitary manner which had the potential to affect the 162 residents who were served food from the kitchen. Findings include: During an initial kitchen tour with the registered dietitian (RD) on 12/2/13, at 1:50 p.m. the following was observed and was verified by the RD at the time: (1) A random selection of six square pans ready	21015		

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21015	Continued From page 5	21015		

for use were stored wet with water droplets on the inner and outer sides of the pans;
(2) A fan above the clean dish area had dirty blades and was running on the high speed; and
(3) The tile (4.5 x 4.5 inches in size) wall and stainless steel backsplash on the clean side of the dishwasher was covered in a greasy film that was three tiles high and 17 tiles across.

According to the RD on 12/5/13, at 9:54 a.m., the night shift staff was responsible for cleaning the backsplash area nightly. The Daily Cleaning Schedule was reviewed and directed night shift staff to wipe down the white wall and stainless steel on the clean side of the dishwasher.

SUGGESTED METHOD OF CORRECTION:
The registered dietitian or designee could ensure staff are following the daily cleaning schedule through random audits.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3759

December 16, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5338024, H5338020

Dear Mr. Spates:

The above facility was surveyed on December 2, 2013 through December 5, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5338020. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Minnesota Department of Health, 1400 East Lyon Street Marshall, Minnesota 56258-2529. 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 Kathryn Serie at (507) 537-7158.

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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5338s14lic.rtf