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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CRP4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00116

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/30/2014** (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 **112** (L18)

13.Total Certified Beds **112** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathryn Serie, Unit Supervisor — 02/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 04/10/2014 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/14/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-24-5372

St Lukes Lutheran Care Center was not in substantial compliance with Federal participation requirements at the time of the December 18, 2013 standard survey. On January 30, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the December 18, 2013 standard survey, effective January 21, 2014. Refer to the CMS-2567b for health.

Effective January 21, 2014, the facility is certified for 112 Skilled Nursing Facility Beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5372

April 10, 2014

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

Dear Ms. Brandt:

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

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

Effective January 21, 2014 the above facility is certified fo:

112 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 112 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
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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

February 6, 2014

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

RE: Project Number S5372023

Dear Ms. Brandt:

On January 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 30, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2013, effective January 21, 2014 and therefore remedies outlined in our letter to you dated January 3, 2014, 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.

Sincerely,

Kathy Serie, Unit Supervisor
Licensing and Certification Program
Telephone: 507-537-7158 Fax: 507-344-2723

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245372	A. Building B. Wing	1/30/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **01/21/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **01/21/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/21/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/21/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/KS	02/06/2014	03048	01/30/2014
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?	YES	NO
12/18/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CRP4

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(L1) **245372**

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/18/2013** (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 **112** (L18)

13.Total Certified Beds **112** (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
	112			
(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 :
Joseph Garvey, HFE NE II — 01/16/2014 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245372

At the time of the standard survey completed December 18, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7352

January 3, 2014

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

RE: Project Number S5372023

Dear Ms. Brandt:

On December 20, 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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 27, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 18, 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 18, 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.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 01/03/2014
FORM APPROVED
OMB NO. 0938-0391

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
	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000		
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 services in a dignified manner for 1 of 3 residents (R47) reviewed for dignified personal care. Findings include: R47, recently admitted on 7/11/13, had diagnoses which included acute ischemic stroke, delusions, depression, visual field deficit and urinary incontinence. R47's quarterly Minimum Data Set (MDS) assessment, dated 11/19/13, identified R47 with intact cognition and no long or short term memory impairment. R47 was identified with multiple indicators of depression and	F 241	See attached approved KMS 1/16/14	

RECEIVED
JAN 15 2014
Minnesota Department of Health
Marshall

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Brandt — TITLE: administrator — (X6) DATE: 1-15-14

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

PRINTED: 01/03/2014
FORM APPROVED
OMB NO. 0938-0391

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
	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 demonstrated some delusional thoughts. During observation of morning cares on 12/18/13 at 7:55 a.m. R47 wheeled himself from the dining room to his room. After arriving in his room, R47 was administered an albuterol nebulizer treatment via a mask which covered the nose and mouth. At 8:18 a.m. R47 was observed to have the nebulizer mask on his face. Although the nebulizer machine continued to be operational, no medication mist was visualized nor was any liquid evident in the medication receptacle. At 8:24 a.m. R47 was observed to have the nebulizer treatment 'running' yet, without medication being administered. The mask was pressed up against his glasses, pushing them up onto his forehead while he was asleep in the wheelchair. At 8:38 a.m. R47 continued to have the nebulizer apparatus on his face without the presence of the medication mist. The nebulizer machine continued to be switched 'on'. R47's nebulizer mask was noted to no longer be located over the mouth, but the top of the mask was pressed against his forehead. During an interview on 12/18/13 at 8:40 a.m. R47 stated he needed to blow his nose and couldn't because of, "this damn thing" and pointed to the mask. When questioned whether he was able to remove the mask, he replied the nurses had to remove it. R47 had the nebulizer mask applied over his mouth and nose for 40 minutes. The typical duration of a nebulizer treatment was identified to be between 5 to 15 minutes or until a mist ceases to be visualized from the nebulizer port. During an interview on 12/18/13 at 11:05 a.m. registered nurse (RN)-A stated staff should	F 241		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 remove the nebulizer mask upon completion of the treatment and turn off the machine. The RN stated R47 had been assessed for self administration of the nebulizer treatment related to keeping the mask on his face but had not been assessed related to his ability to remove the mask. Since the nebulizer mask had been applied to his face for an excessive duration, R47 expressed the frustration of not being 'allowed' to remove the mask when he had the need to blow his nose. During review of the resident council notes dated 11/7/13 and located under 'old business' heading, it was noted there was a concern addressed by residents related to the time it took staff to return and remove the nebulizer treatments after completion of the treatment.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to afford 2 of 3 residents (R72 & R97) reviewed the right to make choices about their personal cares. Findings include:	F 242	see attached	

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	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

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F 242	Continued From page 3 During an interview on 12/16/13 at 4:46 p.m. R72 stated she used to received two baths weekly but was informed she could no longer get but one bath each week. She indicated there was not enough staff to operate the tub in the evening. R72 further revealed that her schedule had been to receive one bath on the day shift each week and one bath on the evening shift, however, she was no longer allowed to an evening bath. During an interview on 12/18/13 at 7:30 a.m., nursing assistant (NA)-A stated residents who used to get more than one bath a week only receive one bath now because they used to provide evening baths. NA-A stated evening baths ceased because there was a shortage of staff and the inability to find anyone to do the evening baths. NA-A confirmed there had been several residents who had routinely received evening baths but no longer got them because of a shortage of staff. During an interview on 12/18/13 at 8:10 a.m. registered nurse (RN) A verified the bathing schedules had been changed due to staffing issues. RN-A stated she had discussed with the residents the issue with staffing and asked if they were alright with one bath each week and she thought the residents were fine with the decision. During an interview on 12/18/13 at 8:55 a.m. NA-B stated residents were no longer offered evening baths because there was not enough available staff. NA-B stated that since all of the college students had returned to school, there was not enough staff to offer evening baths.	F 242		

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	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4 During interview with the director of nursing (DON) and RN-A on 12/18/13 at 10:00 a.m. it was verified the bathing schedule had changed due to staffing shortage problems on the evening shift. The DON stated she thought the concern had been discussed during resident council. However, during review of the resident council meeting minutes, it was noted there had been no discussion during the meetings related to the change and elimination of the evening bathing schedules. During further interview with the DON on 12/18/13 at 11:15 a.m. she verified the changes had not been discussed during resident council meetings. During interview with R97 on 12/18/13 at 11:20 a.m. R97 stated she had been notified by staff regarding the inability to receive more than one bath each week instead of the previous schedule which had included two baths/week. R97 indicated her preference had been to have to continue to receive two baths weekly. R97 confirmed she had attended resident council meetings and that there had been no discussion with the members related to the elimination of an evening bathing schedule.	F 242		
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	F 282	see attached	

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	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

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F 282	Continued From page 5 by: Based on observation, interview and document review the facility failed to follow the plan of care related to grooming needs for 1 of 3 residents (R28) reviewed who were dependent upon staff for assistance with activities of daily living. Findings include: R28 failed to receive assistance with grooming needs, as directed by the plan of care. R28 was admitted with diagnoses that included: dementia with functional decline, psychotic symptoms with delusions and hallucinations, delusional disorder with paranoia, macular degeneration and Alzheimer's type dementia with behavioral dyscontrol. The care plan indicated that R28 required extensive assistance with dressing, grooming and bathing. The goal identified for R28 included: will be neat and clean daily. Interventions included: the nursing staff would assist with combing hair, shaving and application of deodorant. During observation of afternoon cares on 12/16/13 at 4:45 p.m., facial hair was noted on the chin and upper lip of R28, approximately 5 mm long. On 12/17/13 at 2:35 p.m., same facial hair noted on chin and upper lip. On 12/18/2013 at 8:16 a.m., the facial hair was still present. On 12/18/13 at 8:20 a.m. during an interview with licensed practical nurse (LPN)-A, it was stated it was protocol to shave residents' daily or when stubble is noted. LPN-A verified that R28 had not been shaved and they were unable to find razor. On 12/18/13 at 8:25 a.m., registered nurse	F 282		

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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
	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

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F 282	Continued From page 6 (RN)-B verified the razor was in R28's room and that all residents have one. On 12/18/2013 at 12:20 p.m., RN-B further verified that R28 required assistance of 1 staff with grooming needs and the expectation was that R28 should be shaved as soon as facial stubble is noted. Review of the facility protocol for personal cares, dated 01/11, indicated that a.m. (morning) cares included: hair should be combed, brushed and facial hairs shaved. The plan of care had not been provided for R28 as written. The notable facial hair (approximately 5 mm long) was present throughout the survey and staff failed to provide R28 with the required grooming needs.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide grooming services for 1 of 3 residents (R28) reviewed who were dependent upon staff for personal care needs. Findings include: Staff failed to provide appropriate grooming	F 312	see attached	

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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
	245372	A. BUILDING _____ B. WING _____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 7 services to R28, who was unable to perform personal care needs without extensive assistance from staff. R28 was admitted with diagnoses that included: dementia with functional decline, psychotic symptoms with delusions and hallucinations, delusional disorder with paranoia, macular degeneration and Alzheimer type dementia with behavioral dyscontrol. The quarterly assessment dated 11/1/13 indicated R28 required extensive assist of 1-2 staff with personal hygiene. The care plan indicated that R28 required extensive assistance with dressing, grooming and bathing. The goal identified for R28 included: will be neat and clean daily. Interventions included: the nursing staff would assist with combing hair, shaving and application of deodorant. During observation of afternoon cares on 12/16/13 at 4:45 p.m., facial hair was noted on the chin and upper lip of R28, approximately 5mm long. On 12/17/13 at 2:35 p.m., same facial hair noted on chin and upper lip. On 12/18/2013 at 8:16 a.m., the facial hair was still present. On 12/18/13 at 8:20 a.m. during an interview with licensed practical nurse (LPN)-A, it was stated it was protocol to shave residents' daily or when stubble is noted. LPN-A verified that R28 had not been shaved and they were unable to find razor. On 12/18/13 at 8:25 a.m., registered nurse (RN)-B verified the razor was in R28's room and that all residents have one. On 12/18/2013 at 12:20 p.m., RN-B further verified that R28 required assistance of 1 staff with grooming needs and the expectation was that R28 should be shaved as soon as facial stubble is noted.	F 312		

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	245372	A. BUILDING _____ B. WING _____	12/18/2013

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

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F 312	Continued From page 8 Review of the facility protocol for personal cares, dated 01/11, indicated that a.m. (morning) cares included: hair should be combed, brushed and facial hairs shaved. Notable facial hair (approximately 5 mm long) was evident throughout the survey without staff intervention to provide the necessary care for R28.	F 312		

F241 DIGNITY AND RESPECT OF INDIVIDUALITY

St. Luke's Lutheran Care Center is dedicated to protecting the dignity of each resident by striving to meet their individual spiritual, physical, psychological and emotional needs. In this isolated incident, the nursing staff did not follow the facility's procedure for Nebulizer Administration by checking back with resident R47 after 15 minutes to see if the nebulizer treatment was completed. Nursing staff person involved acknowledged that she had been interrupted, and forgot to check back on the resident.

Director of Nursing posted a memo at each nursing station on 12-18-13 reminding staff to check back with residents receiving nebulizer treatments when treatment should be completed. Timers are available in the medication rooms if nursing staff want to use them as a reminder for checking back on residents receiving nebulizer treatments.

All nursing staff involved in the administration of medications and treatments receive an orientation to the facility's procedure for nebulizer administration upon hire.

All Nursing Department staff members are required to attend an in-service session on 1/17/14 or 1/20/14 that will cover the following topic:

1. Review of facility's procedure for nebulizer administration

Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test.

On a weekly basis for one month and then on a monthly basis, the RN Education Coordinator, RN Evening Shift Supervisor and Night Shift Coordinator or their designee, will randomly audit nebulizer administrations to assure compliance with the facility's procedure for nebulizer administration. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring.

The Director of Nursing is responsible for overall compliance with this regulation.

Completion Date: January 21, 2014

F242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES

It is the intent of St. Luke's Lutheran Care Center to create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Upon admission, residents are interviewed to determine their choices for personal activities including the timing and method for bathing. The resident's choice is scheduled and reviewed at least quarterly to determine if the resident is satisfied. Upon admission, Social Services staff review resident rights with the resident and/or their family, and inform them to notify facility staff at any time if not satisfied with cares.

Starting in October 2013, staffing availability interfered with the facility's ability to continue providing an evening bath aide. RN Resident Care Coordinators interviewed each resident who had received an evening bath or had received 2 baths per week to determine if they would be satisfied with a temporary arrangement to provide weekly morning tub or shower baths in addition to assistance as needed with daily sponge bathing with am and hs cares. Residents who required more frequent tub or shower bathing for special conditions, continued to receive more than one tub or shower bath per week. The facility planned to resume its usual morning and evening tub bath or shower options when staffing

became available. When the RN Resident Care Coordinators interviewed the effected residents, R72 and R97, it was their understanding that the residents were satisfied with the temporary change in their respective bathing schedules.

At this time, scheduling availability has changed allowing morning and evening tub and showers to be offered again. Residents whose original bathing schedules were revised are being revisited to assure tub baths or showers are scheduled according to their preference.

On an ongoing basis, residents and/or family members will be interviewed upon admission and at least quarterly to determine their schedule preferences in order to accommodate their requests.

The Resident Council Advisor will review resident rights to make choices about their personal cares at the next scheduled Resident Council Meeting February 6, 2014.

All Nursing Department staff members are required to attend an in-service session on 1/17/14 or 1/20/14 that will cover the following topic:

1. Review of federal regulation regarding resident's self-determination - right to make choices
2. Review facility protocol for interviewing residents to determine resident choice regarding personal cares

Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test.

On a weekly basis for one month and then on a monthly basis, the Director of Nursing or her designee will randomly interview residents to determine if their choices about personal cares are being followed. The results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring.

The Director of Nursing is responsible for overall compliance with this regulation.

Completion Date: January 21, 2014

F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

St. Luke's Lutheran Care Center care plan standard is well defined. In this isolated incident, the nursing assistants did not follow the facility's standard of providing care in accordance with the comprehensive care plan for R28 when they failed to shave her facial hairs.

The standard of providing cares according to the comprehensive care plan is included in the New Employee Orientation Program for all Nursing Department staff. All nursing staff members are involved in the care planning process and are accountable for following the comprehensive care plan when providing cares.

Nursing staff can easily identify care plan interventions for residents by referring to the following forms that serve to supplement the comprehensive care plan:

1. In-Room Care Plan
2. Resident Assignment Sheets (Designed to be carried by nursing assistants during their shift)

Nursing Department staff members are required to attend an in-service session on 1/17/14 or 1/20/14 that will cover the following topic:

1. Review of facility standard of providing care in accordance with the comprehensive care plan.

Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test.

On a weekly basis for one month, and then on a monthly basis, the RN Education Coordinator, the Evening Shift Supervisor and the Night Shift Coordinator will randomly monitor resident cares to ensure that cares are being provided according to the resident care plan. Results will be reported to the Director of Nursing to guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will reevaluate the need and frequency for continued compliance monitoring.

The Director of Nursing or her designee is responsible for overall compliance with this regulation.

Completion date: January 21, 2014

F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

St. Luke's Lutheran Care Center's Personal Cares Protocol is well defined. In this isolated incident, the nursing staff did not follow facility protocol for R28 for AM cares that directs staff to shave facial hairs.

The facility's Personal Cares Protocol is included in the New Employee Orientation Program for all Nursing Department Staff.

Director of Nursing posted a memo at each nursing station on 12-18-13 reminding staff that residents should be checked for facial hair and shaved as needed with am cares.

All Nursing Department staff members are required to attend an in-service session on 1/17/14 or 1/20/14 that will cover the following topic:

1. Review of facility's Personal Cares Protocol

Staff members who are unable to attend will be required to read a packet covering in-service material and complete a post test.

On a weekly basis for one month and then on a monthly basis, the RN Education Coordinator, RN Evening Shift Supervisor and Night Shift Coordinator or their designee, will randomly audit resident cares to ensure compliance with facility's Personal Cares Protocol. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring.

The Director of Nursing is responsible for overall compliance with this regulation.

Completion Date: January 21, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/20/2013**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 20, 2013. At the time of this survey, Building 01 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Building 01 of St. Luke's Lutheran Care Center was constructed as follows: The original building was constructed in 1963, is one-story in height, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1969 building addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction; The 1975 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111)construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 108 at time of the survey.	K 000		

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

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

F5372023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **02 - BUILDING 2** B. WING _____	**12/20/2013**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 20, 2013. At the time of this survey, Building 02 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of St. Luke's Lutheran Care Center consists of the 2005 building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 108 at time of the survey.	K 000		

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FB372023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING **03 - 2008 ADDITION** B. WING _____	**12/20/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 20, 2013. At the time of this survey, Building 03 of St. Luke's Lutheran Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 03 of St. Luke's Lutheran Care Center consists of the 2008 mechanical building addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and in all spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 112 beds, and had a census of 108 at time of the survey.	K 000		

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

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