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: CZEB
Facility ID: 00605

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245590**
2. STATE VENDOR OR MEDICAID NO. (L2) **751243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN HOME**
(L4) **611 WEST MAIN STREET**
(L5) **BELLE PLAINE, MN** (L6) **56011**

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 **11/22/2016** (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 **97** (L18)
13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
	97			
(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 :
Lisa Hakanson, HFE NEII 12/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1992** (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 **11/18/2016** (L33)

DETERMINATION APPROVAL

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

CCN: 245590

On November 22, 2016, a Post Certification Revisit (PCR) was completed by the Department of Health and on October 31, 2016, by the Department of Public Safety to verify comliance with deficiencies issued pursuant to the extended survey completed on September 23, 2015. Based on our PCR, we have deteremined deficiencies issued pursuant to the extended survey completed on September 23, 2016 were corrected, effective October 30, 2016.

As a result of the survey findings, the Department is discontinuing the Category 1 remedy of State monitoring as of October 30, 2106.

- Civil money penalty for the deficiency cited at F226, remain in effective, and discontinued as of October 30, 2016.

The facility would be subject to a two year loss of NATCEP beginning September 23, 2016 as a result of the extended survey that identified substandard quality of care.

Refer to the CMS 2567b for both health and life safety code.

Effective October 30, 2016 the facility is certified for 97 skilled nursing facility beds.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245590

January 25, 2017

Mr. Craig Smith, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

Dear Mr. Smith:

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 October 30, 2016 the above facility is certified for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 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 / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

REVISED

Electronically delivered
January 5, 2017

Mr. Craig Smith, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

RE: Project Number S5590027

Dear Mr. Smith:

On October 10, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective October 15, 2016. (42 CFR 488.422)

In addition, on October 10, 2016, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 23, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on September 23, 2016. The most serious deficiency was found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 31, 2016, the Minnesota Departmetn of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 23, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 30, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on September 23, 2016, as of October 30, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 30, 2016.

In addition, the Department recommended the following enforcement action to the CMS Region V Office as it relates to the remedies in our letter of October 10, 2016:

- Civil money penalty for the deficiency cited at F226, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 23, 2016 be rescinded. (42 CFR 488.417 (b))

Furthermore, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 23, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department. 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 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 eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245590		11/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 10/30/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 10/30/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 10/30/2016
ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 10/30/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 10/30/2016	ID Prefix F0463 Reg. # 483.70(f) LSC	Correction Completed 10/23/2016
ID Prefix F0497 Reg. # 483.75(e)(8) LSC	Correction Completed 10/30/2016	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 (INITIALS) GL/KJ	DATE 12/02/2016	SIGNATURE OF SURVEYOR 28230	DATE 11/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/23/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245590	A. Building 02 - 1961, 1970, 1998 ADDITIONS B. Wing	10/31/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 09/22/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/22/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 12/02/2016	SIGNATURE OF SURVEYOR 37008	DATE 10/31/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 2, 2016

Mr. Craig Smith, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, MN 56011

Re: Reinspection Results - Project Number S5590027

Dear Mr. Smith:

On November 22, 2016 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 September 23, 2016, with orders received by you on . At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00605 Y1	Y2	11/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20300 Reg. # MN Rule 4658.0105 LSC	Correction Completed 10/23/2016	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 10/23/2016	ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. 2.B LSC	Correction Completed 10/23/2016
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 10/23/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 10/23/2016	ID Prefix 21990 Reg. # MN St. Statute 626.557 Subd. 4 LSC	Correction Completed 10/23/2016
ID Prefix 22000 Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c) LSC	Correction Completed 10/23/2016	ID Prefix 23010 Reg. # MN Rule 4658.4635 A LSC	Correction Completed 10/23/2016	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 (INITIALS) GL/KJ	DATE 12/02/2016	SIGNATURE OF SURVEYOR 28230	DATE 11/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/23/2016	☐ 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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CZEB
Facility ID: 00605

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245590**

2. STATE VENDOR OR MEDICAID NO. (L2) **751243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN HOME**
(L4) **611 WEST MAIN STREET**
(L5) **BELLE PLAINE, MN** (L6) **56011**

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 **09/23/2016** (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 **97** (L18)

13.Total Certified Beds **97** (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)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(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 :
Douglas Stevens, HFE NEII 10/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(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: 245590

On September 23, 2016, an extended survey was completed at this facility. Conditions in the facility constituted substandard quality of care to resident health or safety. The survey found the most serious deficiency to be widespread deficiencies that constitute no actual harm with potential form more than minimal harm that was not immediate jeopardy (Level F). In addition at the time of the extended suryve an investigation of complaint number H55990022 was conducted and found to be unsubstantiated. As a result of the survey findings, the Department impose the Category 1 remedy of State monitoring, effective October 15, 2016.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F226.

The facility would be subject to a two year loss of NATCEP beginning September 23, 2016 as a result of the extended survey that identified substandard quality of care. Refer to the CMS 2567 for both health and life safety along with the facility's plan of correction. Post Certification Revisit to follow.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 10, 2016

Mr. Craig Smith, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

RE: Project Number S5590027 and H5590022

Dear Mr. Smith:

On September 23, 2016, an extended 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. Conditions in the facility at the time of the extended survey constituted Substandard Quality of Care (SQC) to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) , as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the September 23, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H55990022 that was found to be unsubstantiated.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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 electronic plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when Substandard Quality of Care (SQC) has been identified on the current survey. The current survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective October 15, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 23, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations,

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 23, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board’s Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this

letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 December 23, 2016 (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 March 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING ______ B. WING ______	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. An extended survey was also conducted by the Minnesota Department of Health on 9/23/16. An investigation of complaint H5590022 was also completed at the time of the standard survey and was found not substantiated.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		10/30/16

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

Electronically Signed — 10/20/2016

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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F 225	Continued From page 1 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State agency (SA) for by 6 of 7 residents (R17, R39, R61, R66, R129, R157) who were reviewed for abuse prohibition. This also potentially affected all 90 residents residing in the facility. Findings include: The facility's Vulnerable Adult Reporting Tool revealed the following: 1. R66 had a left femoral neck fracture; the time	F 225	Individual Residents events found not in Compliance were reviewed by the Management team. The Vulnerable Adult reporting Policy was updated to reflect the Minnesota language of reporting “Immediately” to SA (CEP) and Administrator; eliminating the language of “no later than 24 hours” as stated in the Federal Language. A Copy of the new Policy was given to the Survey team on 9/22/16. Nurse Managers and other key staff were educated immediately on the States interpretations/expectations, with the new	

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F 225	Continued From page 2 of the incident was 4:00 p.m. on 7/17/16. The event was reported to the Minnesota Department of Health (MDH) by licensed social worker (LSW)-A on 7/18/16. The investigative report (7/18/16) indicated, "Social Worker, DON [director of nursing], and administrator notified within 24 hours." 2. R39 had a physical injury that was not reasonably explained with the date and time of the incident "unknown." The incident report was completed 8/9/16. The event was reported to MDH by registered nurse (RN)-C on 8/10/16. The investigative report (8/10/16) indicated, "DON, administrator were updated immediately." 3. R17 had physical injury that could not be reasonably explained dated 3/24/16 with the date and time on the report "unknown." The event was reported to MDH by licensed practical nurse (LPN)-G on 3/25/16. The record did not indicate the administrator was immediately notified. 4. R61 had an event reported to MDH on 8/27/16. The date and time on the incident report was 8/27/16, at 12:58 a.m. The initial report document to the MDH, indicated a telephone call was made to the the Common Entry Point on 8/27/16 to report the event. The event was later reported to MDH by activity aide-A on 8/30/16, through the online reporting system. The investigative report (8/30/16) indicated "Families, DON, Charge Nurse, administrator, and MD [physician] notified of incident." 5. R129 had an abrasion/rug burn to the right side dated 4/4/16. The date and time on the incident report was "4/4/16 at 8:15 p.m. The event was reported to MDH by the LSW-A on 4/5/16.	F 225	Policy taking effect 9/22/16. Remaining Staff were educated through In-services/training regarding the importance of reporting any potential or suspicious events as described in the policy “immediately” to their supervisor or the SA (CEP) and Administrator. Training was also provided to staff on what are Reportable events as described by State and Federal Regulations; our internal investigation process, and the follow up requirement of submitting report to SA (CEP) within 5 days. Social Service will audit future Reportable events as to the timeliness of being reported to the SA (CEP) and present those audit findings to our QA Committee on a quarterly basis.	

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F 225		F 225		

Continued From page 3

The record did not indicate the administrator was immediately notified of the event.

6. R157 had physical injury that could not be reasonably explained. The date and time on the incident report was 10/24/16, at 5:10 a.m. There was no evidence who had reported the event or when it had been reported, as the pages were not included in the information provided by the facility. An Oracle email was dated 10/27/15, at 2:35 p.m. The record did not indicate the administrator was immediately notified of the event.

On 9/22/16, at 10:27 a.m. LSW-B stated that when an event was discovered, it was reported to the charge nurse, director of nursing, or administrator. "If it is something that we feel like we need to report right away, we will fill out an incident report and submit to MDH within the 24 hours during the weekend...We will bring the incident reports to our interdisciplinary team meeting [IDT] and we will discuss it further. At that point, the team will decide to report Vulnerable Adult issues within the 24 hours to the Department of Health." LSW-B explained the facility staff often did not report "immediately" as the facility policy indicated they had up to 24 hours, and they reported within that timeframe. Later that day at 12:22 p.m. LSW-B stated in an interview regarding R17 that a nurse had reported the event by telephone on 8/27/16, and "It was then completed online on 8/30/16." LSW-B reiterated they were following the policy that they were to report "no longer than 24 hours from the time initial knowledge that the incident occurred has been received."

The DON stated in an interview on 9/22/16, at

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F 225	Continued From page 4	F 225		

10:30 a.m. events needed "to be reported to [facility] staff immediately, but the actual report to the MDH can be up to 24 hours in time." The DON further explained the charge nurse was to be informed of all events, including during the night. The charge nurse then determined whether the situation was "reportable" and "may" call the DON or administrator. The event reports were filled out by the nurse and reporting made to MDH if it was determined to be a reportable situation. The DON reviewed R157, R129 and R61's events and verified none of the situations were immediately reported using the online reporting system as required. She explained that there had been confusion regarding the required time frame for reporting and whether the facility had 24 hours to report.

LSW-A explained on 9/22/16, at 12:38 p.m. facility staff followed their policy and procedure which indicated they had up to 24 hours to report to the MDH.

Licensed practical nurse (LPN)-C stated on 9/22/16, at 2:01 p.m. if an event happened on the weekend, "we would report on it first thing Monday morning to the IDT team." If it was a fall with an injury, they informed LSW-A. "If we felt it was warranted to continue with the process and report it we would during the weekend."

The administrator stated in an interview on 9/23/16, at 8:31 a.m. he was to be informed of any events such as falls, someone who needed outside intervention or suspicious events that may be reportable immediately. He evaluated the facts of the situation and them they made a decision about reporting to MDH at that time. If it was reportable, the registered nurse (RN)

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F 225	Continued From page 5 supervisor "should report it." The administrator said they could contact him at anytime, 24 hours a day. He explained they would immediately remove any staff suspected or involved in a situation. The facility's undated Vulnerable Adult Reporting Tool reviewed on 9/23/16 indicated "*** If any of the above potential reportable incidents occur Administrator must be notified immediately, but no later than 24 hours ***." The facility's 3/30/16, Vulnerable Adult Report policy indicated, "Immediately is defined as: as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received...The Administrator and the Director of Nursing will be notified on any unknown injuries within 24 hours of onset...Reportable incidents must also be electronically sent to the Minnesota Department of Health with 24 hours of the incidents discovery as required at 42 CFR 483.13 (C) (2) [Centers for Medicare and Medicaid Services regulatory reference]."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 226	The Vulnerable Adult reporting Policy	10/30/16

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F 226	Continued From page 6 facility failed to develop and operationalize abuse prohibition policies that included immediately reporting of allegations to the administrator and designated State agency (SA) for 6 of 7 residents (R17, R39, R61, R66, R129, R157), and potentially affecting all 90 residents residing in the facility. Findings include: The facility's undated Vulnerable Adult Reporting Tool reviewed on 9/23/16 indicated "*** If any of the above potential reportable incidents occur Administrator must be notified immediately, but no later than 24 hours ***." The facility's 3/30/16, Vulnerable Adult Report policy indicated, "Immediately is defined as: as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received...The Administrator and the Director of Nursing will be notified on any unknown injuries within 24 hours of onset...Reportable incidents must also be electronically sent to the Minnesota Department of Health with 24 hours of the incidents discovery as required at 42 CFR 483.13 (C) (2) [Centers for Medicare and Medicaid Services regulatory reference]." The facility's Vulnerable Adult Reporting Tool revealed the following: 1. R66 had a left femoral neck fracture; the time of the incident was 4:00 p.m. on 7/17/16. The event was reported to the Minnesota Department of Health (MDH) by licensed social worker (LSW)-A on 7/18/16. The investigative report (7/18/16) indicated, "Social Worker, DON	F 226	was updated to reflect the Minnesota language of reporting "Immediately" to SA (CEP) and Administrator; eliminating the language of "no later than 24 hours" as stated in the Federal Language. A Copy of the new Policy was given to the Survey team on 9/22/16. Nurse Managers and other key staff were educated immediately on the States interpretations/expectations, with the new Policy taking effect 9/22/16. Remaining Staff were educated through In-services/training regarding the importance of reporting any potential or suspicious events as described in the policy "immediately" to their supervisor or the SA (CEP) and Administrator. Training was also provided to staff on what are Reportable events as described by State and Federal Regulations; our internal investigation process, and the follow up requirement of submitting report to SA (CEP) within 5 days. Social Service will audit future Reportable events as to the timeliness of being reported to the SA (CEP) and present those audit findings to our QA Committee on a quarterly basis.	

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[director of nursing], and administrator notified within 24 hours."

2. R39 had a physical injury that was not reasonably explained with the date and time of the incident "unknown." The incident report was completed 8/9/16. The event was reported to MDH by registered nurse (RN)-C on 8/10/16. The investigative report (8/10/16) indicated, "DON, administrator were updated immediately."

3. R17 had physical injury that could not be reasonably explained dated 3/24/16 with the date and time on the report "unknown." The event was reported to MDH by licensed practical nurse (LPN)-G on 3/25/16. The record did not indicate the administrator was immediately notified.

4. R61 had an event reported to MDH on 8/27/16. The date and time on the incident report was 8/27/16, at 12:58 a.m. The initial report document to the MDH, indicated a telephone call was made to the the Common Entry Point on 8/27/16 to report the event. The event was later reported to MDH by activity aide-A on 8/30/16, through the online reporting system. The investigative report (8/30/16) indicated "Families, DON, Charge Nurse, administrator, and MD [physician] notified of incident."

5. R129 had an abrasion/rug burn to the right side dated 4/4/16. The date and time on the incident report was "4/4/16 at 8:15 p.m. The event was reported to MDH by the LSW-A on 4/5/16. The record did not indicate the administrator was immediately notified of the event.

6. R157 had physical injury that could not be reasonably explained. The date and time on the

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LUTHERAN HOME	**611 WEST MAIN STREET** **BELLE PLAINE, MN 56011**

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incident report was 10/24/16, at 5:10 a.m. There was no evidence who had reported the event or when it had been reported, as the pages were not included in the information provided by the facility. An Oracle email was dated 10/27/15, at 2:35 p.m. The record did not indicate the administrator was immediately notified of the event.

On 9/22/16, at 10:27 a.m. LSW-B stated that when an event was discovered, it was reported to the charge nurse, director of nursing, or administrator. "If it is something that we feel like we need to report right away, we will fill out an incident report and submit to MDH within the 24 hours during the weekend...We will bring the incident reports to our interdisciplinary team meeting [IDT] and we will discuss it further. At that point, the team will decide to report Vulnerable Adult issues within the 24 hours to the Department of Health." LSW-B explained the facility staff often did not report "immediately" as the facility policy indicated they had up to 24 hours, and they reported within that timeframe. Later that day at 12:22 p.m. LSW-B stated in an interview regarding R17 that a nurse had reported the event by telephone on 8/27/16, and "It was then completed online on 8/30/16." LSW-B reiterated they were following the policy that they were to report "no longer than 24 hours from the time initial knowledge that the incident occurred has been received."

The DON stated in an interview on 9/22/16, at 10:30 a.m. events needed "to be reported to [facility] staff immediately, but the actual report to the MDH can be up to 24 hours in time." The DON further explained the charge nurse was to be informed of all events, including during the night. The charge nurse then determined whether

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the situation was "reportable" and "may" call the DON or administrator. The event reports were filled out by the nurse and reporting made to MDH if it was determined to be a reportable situation. The DON reviewed R157, R129 and R61's events and verified none of the situations were immediately reported using the online reporting system as required. She explained that there had been confusion regarding the required time frame for reporting and whether the facility had 24 hours to report.

LSW-A explained on 9/22/16, at 12:38 p.m. facility staff followed their policy and procedure which indicated they had up to 24 hours to report to the MDH.

Licensed practical nurse (LPN)-C stated on 9/22/16, at 2:01 p.m. if an event happened on the weekend, "we would report on it first thing Monday morning to the IDT team." If it was a fall with an injury, they informed LSW-A. "If we felt it was warranted to continue with the process and report it we would during the weekend."

The administrator stated in an interview on 9/23/16, at 8:31 a.m. he was to be informed of any events such as falls, someone who needed outside intervention or suspicious events that may be reportable immediately. He evaluated the facts of the situation and them they made a decision about reporting to MDH at that time. If it was reportable, the registered nurse (RN) supervisor "should report it." The administrator said they could contact him at anytime, 24 hours a day. He explained they would immediately remove any staff suspected or involved in a situation.

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F 279	Continued From page 10	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for the provide services to minimize the risk for decreased range of motion (ROM) for 1 of 1 resident (R87) reviewed for ROM services. Findings include: R87 was reported to have a contracture to the right upper extremity (UE) following a stroke according to registered nurse (RN)-A on 9/20/16, at 10:40 a.m.. RN-A reported R87, however, did	F 279	Resident R-87 Care Plan was updated reflecting the contracture and proper treatment was put into place for Nurses: To assure NAR has provided PROM to RUE twice a day starting 9/23/16. Nurse Managers will assess all other in house Residents for possible contractures; and if any found, either refer to Therapies, or an appropriate POC will be developed immediately. These assessments will be completed by 10/17/16	10/30/16

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F 279	Continued From page 11 not utilize a splint, nor ROM services to the affected limb. On 9/21/16, at 11:38 a.m. R87 was in his room. No splint device was in use. When asked, R87 denied he utilized a splint or was provided exercises for the contracture to his right UE. Following the observation and interview with R87 at 11:48 a.m. RN-A explained the resident had utilized a splint in the past, but had refused to wear it during the day and then refused it "all together." RN-A verified R87 was not utilizing a splint nor did he receive ROM services from staff, explaining the resident "does it on his own." Staff were not monitoring or documenting any information related to R87's ROM or contracture status. A Restorative Nursing Assessment note dated 5/19/14, noted R87 was at risk for contractures and joint stiffness, and staff were advised to provide ROM to prevent contractures and joint stiffness to right upper and lower extremities. R87's care plan dated 4/16/15, indicated the resident was involved with the restorative nursing program and was assisted with walking. The care plan did not direct staff to provide ROM services or to apply a splint. An Order Communication Form dated 2/16/16, indicated a therapist recommended a hand brace for R87, but the R87 refused to wear it, so it was discontinued and staff were to "continue to monitor." A Restorative Nursing Assessment note dated 3/17/16, stated "discontinuation of restorative	F 279	Nurse Managers will monitor all residents with contractures at a minimum of quarterly and update Care plan as appropriate. Staffs were educated on the importance of ensuring Resident needs are entered on the Care plans; and that we are following each Individualized Resident Care Plan to meet the Resident needs DON will audit on a quarterly basis, that all residents with Contractures have proper POC in place; plus discuss her findings at our QA Committee meetings on a quarterly basis.	

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F 279	Continued From page 12 programs related to non-ambulatory status and non-compliance. Will re-address with PT/OT [physical therapy/occupational therapy] as needed." Neither the current Long Term Care Card or current Guideline For Daily Care sheet directed the NAs to provide exercises or ROM for R87. On 9/22/16, at 7:53 a.m. a nursing assistant (NA)-G reported regarding R87's contracture that she "loosened it up" when providing morning cares, but she denied providing structured ROM services or documentation of completion. During an interview at 7:58 a.m. the occupational therapist (OTR) explained the therapy staff had made a Soft Pro hand splint (used to treat moderate flexion contractures of wrist, hand and thumb). R87 began using the splint on 11/5/14, only wearing the splint at night per his choice. He started to refuse application of the splint towards the beginning of 2016, and consequently the device was discontinued on 2/16/16. She further explained R87 had received restorative ROM and ambulation services, but because the resident refused the ambulation services, the entire program was discontinued since two services were needed to fulfill the requirements of the facility's restorative nursing program. The OTR stated she would have expected nursing to continue to provide ROM when therapy services ended to ensure residents maintained their ROM status, particularly with hemiplegia. On 9/22/16, at 9:04 a.m. RN-A stated ROM for R87 had not been put into the NA's tasks after the restorative program stopped. RN-A stated, "I would have expected this to be done. It falls	F 279		

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F 279	Continued From page 13 under my jurisdiction. It wasn't done." She verified it should have been provided for a resident with hemiplegia. On 9/22/15, at 1:53 p.m. the director of nursing (DON) stated she would have expected when a resident had ROM limitations but had completed therapy, the resident would have been assessed and started on a restorative program to maintain their current status if services were deemed beneficial. The DON also stated she would have expected a care plan to include ROM, therapy and other directions on the care of a resident. The care plan should have been updated as needed to ensure a resident was getting the care they required. The facility's 7/1/16, ROM policy indicated the purpose for ROM "is to move the resident's joints through as full a range of motion as possible, maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent complications of mobility." A care plan policy was requested but not obtained.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		10/30/16

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F 318	Continued From page 14	F 318		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide services to minimize the risk for decreased range of motion (ROM) for 1 of 1 resident (R87) reviewed for ROM services.

Findings include:

R87 was reported to have a contracture to the right upper extremity (UE) following a stroke according to registered nurse (RN)-A on 9/20/16, at 10:40 a.m.. RN-A reported R87, however, did not utilize a splint, nor ROM services to the affected limb.

On 9/21/16, at 11:38 a.m. R87 was in his room. No splint device was in use. When asked, R87 denied he utilized a splint or was provided exercises for the contracture to his right UE.

Following the observation and interview with R87 at 11:48 a.m. RN-A explained the resident had utilized a splint in the past, but had refused to wear it during the day and then refused it "all together." RN-A verified R87 was not utilizing a splint nor did he receive ROM services from staff, explaining the resident "does it on his own." Staff were not monitoring or documenting any information related to R87's ROM or contracture status.

A Restorative Nursing Assessment note dated 5/19/14, noted R87 was at risk for contractures and joint stiffness, and staff were advised to provide ROM to prevent contractures and joint stiffness to right upper and lower extremities.

Resident R-87 Care Plan was updated reflecting the contracture and proper treatment was put into place for Nurses: To assure NAR has provided PROM to RUE twice a day starting 9/23/16.
Nurse Managers will assess all other in house Residents for possible contractures; and if any found, either refer to Therapies, or an appropriate POC will be developed immediately. These assessments will be completed by 10/17/16
Nurse Managers will monitor all residents with contractures at a minimum of quarterly and update Care plan as appropriate.
Staffs were educated on the importance of ensuring Resident needs are entered on the Care plans; and that we are following each Individualized Resident Care Plan to meet the Resident needs

DON will audit on a quarterly basis, that all residents with Contractures have proper POC in place; plus discuss her findings at our QA Committee meetings on a quarterly basis.

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R87's care plan dated 4/16/15, indicated the resident was involved with the restorative nursing program and was assisted with walking. The care plan did not direct staff to provide ROM services or to apply a splint.

An Order Communication Form dated 2/16/16, indicated a therapist recommended a hand brace for R87, but the R87 refused to wear it, so it was discontinued and staff were to "continue to monitor."

A Restorative Nursing Assessment note dated 3/17/16, stated "discontinuation of restorative programs related to non-ambulatory status and non-compliance. Will re-address with PT/OT [physical therapy/occupational therapy] as needed."

Neither the current Long Term Care Card or current Guideline For Daily Care sheet directed the NAs to provide exercises or ROM for R87.

On 9/22/16, at 7:53 a.m. a nursing assistant (NA)-G reported regarding R87's contracture that she "loosened it up" when providing morning cares, but she denied providing structured ROM services or documentation of completion.

During an interview at 7:58 a.m. the occupational therapist (OTR) explained the therapy staff had made a Soft Pro hand splint (used to treat moderate flexion contractures of wrist, hand and thumb). R87 began using the splint on 11/5/14, only wearing the splint at night per his choice. He started to refuse application of the splint towards the beginning of 2016, and consequently the device was discontinued on 2/16/16. She further

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F 318	Continued From page 16 explained R87 had received restorative ROM and ambulation services, but because the resident refused the ambulation services, the entire program was discontinued since two services were needed to fulfill the requirements of the facility's restorative nursing program. The OTR stated she would have expected nursing to continue to provide ROM when therapy services ended to ensure residents maintained their ROM status, particularly with hemiplegia. On 9/22/16, at 9:04 a.m. RN-A stated ROM for R87 had not been put into the NA's tasks after the restorative program stopped. RN-A stated, "I would have expected this to be done. It falls under my jurisdiction. It wasn't done." She verified it should have been provided for a resident with hemiplegia. On 9/22/15, at 1:53 p.m. the director of nursing stated she would have expected when a resident had ROM limitations but had completed therapy, the resident would have been assessed and started on a restorative program to maintain their current status if services were deemed beneficial. The facility's 7/1/16, ROM policy indicated the purpose for ROM "is to move the resident's joints through as full a range of motion as possible, maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent complications of mobility."	F 318		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		10/30/16

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F 441	Continued From page 17 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation interview, and document review, the facility failed to disinfect glucometers	F 441	Professional Nurses were educated on the proper hand washing techniques	

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F 441	Continued From page 18 to minimize the risk of infection for 5 of 5 residents (R50, R128, R45, R158, R87) whose blood glucose monitoring was observed. This had potential to affect 19 other residents who utilized the shared glucometers. In addition, the facility failed to ensure proper handwashing technique was practiced for 1 of 1 resident (R115) who utilized an indwelling catheter. Findings include: R50's glucose monitoring was observed on 9/20/16, at 7:24 a.m. performed by licensed practical nurse (LPN)-A. LPN-A washed her hands for five seconds and donned gloves. She then wiped the glucometer for five seconds with a Super Sani-Wipe, and then set the glucometer on the resident's bed. Following the blood sugar testing, LPN-A wiped the glucometer with another Super Sani-Wipe for three seconds and removed her gloves. LPN-A then washed her hands for five seconds and donned gloves. Using the same glucometer, R45's (R50's roommate) blood sugar was tested by LPN-A. Following the testing LPN-A wiped the glucometer for three seconds, removed her gloves, washed her hands for five seconds. LPN-A returned the glucometer to a a tray on the medication cart that contained opened gauze, lancets, and alcohol wipes. LPN-A was interviewed regarding the facility's procedure for cleaning glucometers on 9/20/16, at 7:32 a.m. LPN-A reported she had used Super Sani-Cloths to clean the glucometers for R50 and R45, and stated, "I just sort of wiped over the glucometer before and after. Glucometers are used for multiple patients. I washed my hands for two seconds and I should have for 15 seconds. I do not know how long I am supposed to wipe the	F 441	immediately upon the discovery of the concern. Other facility staff were also educated on proper handwashing through In services/training Glucometers: On 9/21/16 Policy was reviewed and changes were made to reflect the proper cleaning procedure according to Manufactures Instructions. Nurses were educated with these changes in procedure immediately on 9/21/16. Individual Glucometers were also ordered for the majority of our Residents where appropriate. Nurse Managers will conduct 6 quarterly staff handwashing Audits for a total of 24 audits in the building each Quarter. DON will follow up on Audits and share the results to the Quality Assurance Committee meetings every Quarter.	

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glucometers" (after testing a resident's blood sugar).

R128's blood sugar was tested on 9/20/16, at 8:02 a.m. performed by LPN-B. LPN-B brought the glucometer tray into R128's room and without washing hands, donned gloves. LPN-B then left R128's room wearing one glove and wiped the glucometer with a Super Sani-Cloth for five seconds and placed it on the medication cart for five seconds. LPN-B then removed the glove, used hand sanitizer, and then placed the glucometer in the tray on the medication cart containing opened gauze, lancets, and alcohol wipes.

LPN-B was interviewed on 9/20/16, at 8:06 a.m. She stated, "The glucometers are shared, so we sanitize them before and after each use." LPN-B explained Super Sani-Cloths were used and the staff "just wipe them down and set them down to dry--and they dry quick--and then put it back" (in the tray). "I should've washed my hands before and after using the glucometer."

LPN-C stated in an interview on 9/20/16, at 8:27 a.m. regarding the facility's process for cleaning glucometers, "I would have to ask the night nurse about the glucometer cleaning protocol. We have one glucometer for all our residents. I don't know what the cleaning protocol is."

LPN-D performed blood sugar testing for R45 on 9/21/16, at 7:08 a.m. LPN-D obtained the tray containing glucose testing supplies into the resident's room. LPN-D set the tray on R45's bedside stand and the glucometer on the resident's bed. After testing R45's blood sugar, LPN-D removed her gloves, and without cleaning

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F 441	Continued From page 20 the glucometer, returned it to the tray containing supplies. She then removed her gloves and washed her hands. At 7:12 a.m. LPN-D removed the glucometer from the tray, wiped it briefly using a Super Sani-Cloth, and returned it to the tray. LPN-D explained, "We wipe the glucometer down with 'purple top wipe' and let it air dry. I left it on the med [medication] cart for five seconds and then put it back into tray. We use shared glucometers and have two glucometers in the med med cart on the Special Care unit." R69's fungal rash care was observed on 9/21/16, at 7:21 a.m. LPN-D donned gloves and sprinkled power to R69's right armpit and rubbed it in with her gloved hand. LPN-D then removed her gloves and washed her hands for two seconds. Following the observation LPN-D confirmed she had not washed her hands thoroughly and stated, "I should wash hands for 30 seconds and I only did for two." R87's blood glucose testing was observed on 9/21/16, at 7:37 a.m. performed by trained medication aide (TMA)-A. After gathering supplies, TMA-A placed the tray and glucometer on R87's bed. Following the blood sugar testing, TMA-A returned the glucometer to the medication cart, wiped the glucometer with a Dispatch wipe for 15 seconds, and 10 seconds later, returned it to the tray containing the supplies. TMA-A then explained, "We use the Dispatch Hospital Towels with Bleach. I wiped the glucometer down for 10 seconds and then let it air dry for 10 seconds and then put it in basket with the supplies." TMA-A confirmed the glucometers were shared, and she was responsible for testing six residents' blood sugars that day.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING ______ B. WING ______	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 441	Continued From page 21 R158's glucose testing was observed on 9/21/16, at 9:09 a.m. performed by LPN-E. LPN-E set the tray containing supplies on R158's recliner and placed the testing strips on the resident's breakfast tray. After testing the resident's blood sugar, she returned the glucometer to the cart, wiped it with a Super Sani-Cloth for approximately 15 second, and returned it to the tray without allowing the glucometer to dry. Following the observation, LPN-E explained, "We use Super Sani-Cloths...Take one or two out and wash the glucometer for three to four seconds and put it back in the basket. I let it air dry for three seconds before putting it back in the basket." LPN-E acknowledges she had set the testing strips on R158's breakfast tray. LPN-F was interviewed on 9/21/16, at 11:20 a.m. LPN-F stated the glucometers needed to be cleaned and disinfected using the appropriate wipes. Staff were supposed to wear gloves, pull out a wipe from the dispenser, wipe the device completely, usually for 15-20 seconds. The glucometer was to be completely dried on the medication cart on a clean towel prior to testing another resident using the shared glucometer. LPN-F then read the directions on the Super Sani-Cloth container which indicated, "Disinfect: unfold clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full 2 minutes, let air dry." LPN-F then stated, "I wipe the glucometer all around, and then set it down with clean towel and let it dry." LPN-F said glucometer training was provided at nursing meetings and new nurses were trained at orientation. Related policies and procedures were available on the computer. LPN-F stated, "We need to retrain staff, which I will do now and I will take the glucometers and clean them	F 441		

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	245590	A. BUILDING ______ B. WING ______	09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 441	Continued From page 22	F 441		

adequately."

RN-A was interviewed regarding glucometers on 9/21/16, at 11:31 a.m. She stated glucometers were to be thoroughly wiped using wipes between resident use, and the glucometers left to dry for one minute on the medication cart. RN-A said the wipes dried very quickly. She obtained Dispatch wipes from the cart and stated, "This product is not the same one I am used to using and I have not seen this one before." The instructions directed the user to wipe the surface with wipe until completely wet and let stand for one minute and allow to air dry.

On 9/21/16, at 11:58 a.m. the director of nursing (DON) stated staff was to utilize either Dispatch or Super Sani-Wipes. The facility's policy directed staff to wipe down glucometers in between uses, but did not indicate how long the glucometer should be left to dry. The DON verified the glucometers were stored with opened gauze and verified, "Currently we put it in the basket and we don't clean them properly because we don't have anything stating how long the glucometers should be cleaned or dried. I will go to the units, clean the glucometers properly, and will separate the supplies, and update the policy."

LPN-B was interviewed regarding hand washing on 9/22/16, at 1:06 p.m. She stated, "We can use hand sanitizer two to three times between hand washes. Hand washing is important before and after any wound cares, blood sugar checks, med passes. You should wash hands for about 20-30 seconds. I was trained right away when starting to work here and annually."

The DON stated on 9/23/16, at 10:23 a.m. she

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F 441	Continued From page 23 expected staff to wash their hands between resident cares. Additionally, staff were instructed to wash their hands upon entering and leaving a resident's room and during medication administration. The facility's 9/1/11, Glucometer policy directs staff to disinfect all 'multiple use' glucometers between every resident use...Wipe glucometer with approved cleaning product--dispatch/Super Sani cloth. 4. Allow the unit to completely dry (2 minutes) based on the wipes manufacturer instructions...The glucometer must be kept in separate area, must not be in with clean supplies used for the procedure. The nurse must complete the cleaning process before moving to another resident." R115's cares were observed on 9/22/16, at 7:23 a.m. by nursing assistant (NA-F). NA-F donned gloves and assisted R115 to use a bedpan. Although R115 had an indwelling Foley catheter (a tube in the bladder to provide continuous urinary drainage), he had requested the bedpan for a bowel movement. After R115 reported he had unsuccessful results, NA-F removed the bedpan, covered R115 with a blanket, handed him the call light, removed her gloves and left the room touching the handle on both sides of the door. When asked why she did not wash her hands after removing her gloves, NA-F explained that she usually went across the hallway to wash her hands, "I know it's not a good thing to do. It's a bad habit." At 7:30 a.m. registered nurse (RN)-A stated it was not acceptable to removed gloves and then leave the room without first washing hands. RN-A	F 441		

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LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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F 441	Continued From page 24 further explained, "It is taught not to use gloves in place of handwashing. When gloves comes off you need to wash your hands." RN-A verified R115 had a positive culture showing a urinary tract infection. The facility's 8/1/16, General Guidelines For Hand Hygiene policy indicated "Hand-washing is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from he spread of infection...Before and after touching wounds of any kind...After touching any item or surface that may have been contaminated with blood...Use friction while scrubbing hands vigorously for at least 20 seconds...."	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 1 resident (R41) reviewed for environmental concerns. In addition, call lights in the memory care unit were not functioning when tested, which had the potential to affect 8 of 28 residents (R5, R30, R45, R73, R85, R95, R103, R138) who were capable of using the call light. Findings include:	F 463	Call Light was immediately reinstalled in R 41 Residents bathroom at time of Survey. A check was also completed for call lights in all other Resident rooms and bathrooms during the week of survey. No others were found missing. Call light system in SCR (Memory Care Unit) was reset within 12 minutes of the system going down. Evidence was obtained through a computer generated printout of call light activity on this Unit,	10/23/16

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F 463	Continued From page 25 R41's bathroom call light was not present/available on 9/20/16, at 10:49 a.m. R41 explained, "It has been gone awhile. One night I was up and was going to use it and it was not there." She did not recall how long it had been missing. Licensed practical nurse (LPN)-C was then asked to come to R41's bathroom. LPN-C verified the call light was not present in the resident's bathroom, and stated she would address the issue with maintenance staff immediately. On 9/21/16, at 12:30 p.m. LPN-C reported R41's call light had been missing since 9/15/16, nearly a week prior. LPN-C said the maintenance man went to R41's bathroom to repair the toilet. The call light was on the back of the toilet tank. "He moved it to the plumbing cart to fix the toilet and forgot to put it back where he found it." She further explained that the facility had met and were working on a plan to prevent the problem from happening again. A letter was to be provided with staffs' paychecks on 9/23/16 asking staff to check for the presence and operation of the call lights. In addition, they would continue with monthly call light audits. On 9/23/16, at 7:26 a.m. the campus director of environmental services (DES) stated a maintenance employee had removed the resident call light from the bathroom, which was later found on a cart. He explained that all the staff were to watch for call light function. Problems could be reported using a work order on any of the kiosks or computers. He explained they would continue to do the monthly safety checks. The last monthly safety inspection related to call lights was completed on 8/12/16.	F 463	and was provided to the Surveyor prior to Exit, as was a copy of our Policy regarding what staff are to do when the call lights do go down. The Policy requires checking on all Residents who cannot, or won't, leave their room, every 15 minutes. All other residents will be moved to common areas to be monitored. Staff were re-educated on our Policy of what to do when call lights go down through In-service training. All room and bathroom call lights will be visibly checked on a daily bases when rooms are cleaned by housekeeping. They (housekeeping) will also do checks on all Call lights on a monthly basis consisting of actually testing each light, assuring they are being activated and displayed in the hallway. Results of the daily and monthly checks will be reported to the QA Committee on a Quarterly basis.	

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F 463	Continued From page 26 R154's call light was not working when tested on 9/19/16, at 7:11 p.m. The problem was immediately reported licensed practical nurse (LPN)-F. LPN-F checked the call system and confirmed that actually the whole call light system on the memory care unit was not working. (The system from resident rooms and toilet/bathrooms to the nurse station; and to the nurse/ nursing assistant pagers.) LPN-F stated, "I am not sure what time the system fell. I will call IT [Information Technology] right away to get it fixed." On 9/23/16, at 12:53 p.m. LPN-F stated, "I do not recall if I answered any call lights [on 9/19/16] after lunch. It is the day shift housekeeper's assignment to walk around and check whether the call lights system is functioning or not. I am not sure if the housekeeper had checked the call lights that day. I assume she might have done some kind of check." LPN-F identified eight residents would have been capable of using their call lights on the unit. On 9/23/16, at 1:37 p.m. the administrator stated, "I expect staff to do 15 minute checks. We also have a plan to upgrade the call system on the memory care unit. It has a software problem and it is outdated. Its needs to be upgraded." The facility's Call Light System Failure policy developed 9/23/16, indicated "It is the policy of the Lutheran Home To provide a safe environment for all residents...All resident/staff will be immediately informed of call light system outage."	F 463		
F 497	483.75(e)(8) NURSE AIDE PERFORM	F 497		10/30/16

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F 497 SS=E

Continued From page 27
REVIEW-12 HR/YR INSERVICE

F 497

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide annual performance evaluations for 15 of 15 employees (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15,) whose personnel records were reviewed and had worked in the facility for greater than 12 months. This had the ability to impact all 90 residents in the facility.

Findings include:

On 9/23/16, at 2:00 p.m. evaluations for 10 nursing assistants (NAs) were requested. At approximately 3:15 p.m. the administrator returned with eight employee evaluations (E1, E2, E3, E4, E6, E7, E9, E10) and said "unfortunately the evaluations are not very current." All eight of the evaluations were overdue. In addition, E5 and E8 had not had an evaluation, and the

All active Nursing assistant staff annual reviews which were not current, were completed. All “inactive” (LOA’s; Students; Workers comps; etc.) nursing assistants will have their annual reviews completed prior to returning to work. Reviews will include comments about the positive things they do every day, and also point out “areas of improvement” needed as appropriate for each individual.

Completion of Reviews will be audited by HR and Administration on a monthly basis. Results of this monitoring will be discussed with the Quality Assurance Committee, which meets Quarterly.

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F 497	Continued From page 28	F 497		

administrator explained they were temporary or part time employees. Two additional full time employee evaluations were requested for E11 and E12. E11's had not been completed timely. E12's had not been completed within the year. Three more full time employee evaluations for E13, E14, E15 were requested. E14's was not in the employee's personnel file. E13 and E15 had not had evaluations completed in the past year.

On 09/23/16, at 5:16 p.m. during an interview with human resource employee (HR)-A, she explained that she utilized a tracking system for evaluations and the directors had access to the spread sheet. She further stated the evaluations were "further behind than I would like to be."

Employee date of hire and evaluation dates provided by facility were as follows:

E1's evaluation was effective through 6/21/16
E2's evaluation was effective through 8/5/16
E3's evaluation was effective through 8/22/14
E4's evaluation was effective through 11/9/14
E5's evaluation was not received
E6's evaluation was effective through 5/12/16
E7's evaluation was signed 2/26/15
E8's evaluation was not received
E9's evaluation date was signed 3/5/15
E10's evaluation was dated 8/22/13
E11's dated was signed 3/20/15
E12's evaluation was effective through 3/15/16
E13's evaluation was effective through to 8/6/15
E14's evaluation was not received
E15's evaluation was effective through 2/13/15

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

F5590024

PRINTED: 10/24/2016
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
	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING _______	**09/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**611 WEST MAIN STREET** **BELLE PLAINE, MN 56011**

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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 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/22/2016, Building 02 of Lutheran Home Belle Plaine was found not 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2016

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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	245590	A. BUILDING **01 - MAIN BUILDING 01 1951 ADDITION** B. WING ______	**09/22/2016**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/22/2016, Building 01 of Lutheran Home Belle Plaine 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. This facility will be surveyed as three separate buildings. The original building was built in 1951, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire	K 000		

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

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K 000	Continued From page 2 department notification. Additionally, all resident rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 94 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

F5590024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING 02 - 1961, 1970, 1998 ADDITIONS B. WING ____________	09/22/2016

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LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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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 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/22/2016, Building 02 of Lutheran Home Belle Plaine was found not 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/20/2016

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
	245590	A. BUILDING **02 - 1961, 1970, 1998 ADDITIONS** B. WING _______	**09/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**611 WEST MAIN STREET** **BELLE PLAINE, MN 56011**

(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	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as three separate buildings. The 1st Addition was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 2nd Addition was built in 1970, is two-stories, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 3rd Addition was built in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Additionally, all resident rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 94 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025	NFPA 101 LIFE`SAFETY CODE STANDARD	K 025		9/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **02 - 1961, 1970, 1998 ADDITIONS** B. WING	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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K 025 SS=E	Continued From page 2 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 09:00 AM and 12:00 PM on 9/22/2016, based on observation and interview revealed that a penetration was found above ceiling near room U108.	K 025	The penetration located above the Ceiling Tile near room U108 was filled with a fire resistant material on the same day it was discovered, was corrected by our Maintenance Director (DL)	
	This deficient practice could affect the safety of the (12) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery			
K 062 SS=D	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: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062	The 1" hole next to the shower head in the closet on 2nd Floor was filled with a fire resistant material on the same day as	9/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **02 - 1961, 1970, 1998 ADDITIONS** B. WING	**09/22/2016**

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K 062	Continued From page 3 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 09:00 AM and 12:00 PM on 9/22/2016, based on observation and interview revealed that a 1" hole next to fire sprinkler head in closet on 2nd floor Special Care Residence was found.. This deficient practice could affect the safety of the (6) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 062	discovered, was corrected by our maintenance Director (DL)	

F5590024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245590	A. BUILDING **03 - 2008 KITCHEN/LAUNDRY/OFFICE** B. WING ______	**09/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	**611 WEST MAIN STREET** **BELLE PLAINE, MN 56011**

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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 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 9/22/2016, Building 02 of Lutheran Home Belle Plaine was found not 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2016

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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	245590	A. BUILDING 03 - 2008 KITCHEN/LAUNDRY/OFFICE B. WING	09/22/2016

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LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Building 03 of Lutheran Home Belle Plaine 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. This facility will be surveyed as three separate buildings. The 4th Addition was built in 2008, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Additionally, all resident	K 000		

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
	245590	A. BUILDING **03 - 2008 KITCHEN/LAUNDRY/OFFICE** B. WING	**09/22/2016**

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K 000	Continued From page 2 rooms are protected with automatic smoke detection. The facility has a capacity of 97 beds and had a census of 94 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically delivered
October 10, 2016

Mr. Craig Smith, Administrator
Lutheran Home
611 West Main Street
Belle Plaine, Minnesota 56011

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5590027 and H5590022

Dear Mr. Smith:

The above facility was surveyed on September 19, 2016 through September 23, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5590022. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

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 eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00605	A. BUILDING: ______ B. WING ______	C **09/23/2016**

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LUTHERAN HOME	**611 WEST MAIN STREET** **BELLE PLAINE, MN 56011**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/19/16 through 9/23/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An extended survey was also conducted by the Minnesota Department of Health on 9/23/16. An investigation of complaint H5590022 was completed at the time of the licensing survey. The complaint was not substantiated.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide annual performance evaluations for 15 of 15 employees (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15,) whose personnel records were reviewed and had worked in the facility for greater than 12 months. This had the ability to impact all 90 residents in the facility. Findings include: On 9/23/16, at 2:00 p.m. evaluations for 10 nursing assistants (NAs) were requested. At approximately 3:15 p.m. the administrator returned with eight employee evaluations (E1, E2,	2 300	All active Direct Care Staff annual reviews which were not current, were completed. All “inactive” (LOA’s; Students; Workers comps; etc.) Direct Care Staff will have their annual reviews completed prior to returning to work. Reviews will include comments about the positive things they do every day, and also point out “areas of improvement” needed as appropriate for each individual. Completion of Reviews will be audited by HR and Administration on a monthly basis. Results of this monitoring will be discussed with the Quality Assurance	10/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 300	Continued From page 3 E3, E4, E6, E7, E9, E10) and said "unfortunately the evaluations are not very current." All eight of the evaluations were overdue. In addition, E5 and E8 had not had an evaluation, and the administrator explained they were temporary or part time employees. Two additional full time employee evaluations were requested for E11 and E12. E11's had not been completed timely. E12's had not been completed within the year. Three more full time employee evaluations for E13, E14, E15 were requested. E14's was not in the employee's personnel file. E13 and E15 had not had evaluations completed in the past year. On 09/23/16, at 5:16 p.m. during an interview with human resource employee (HR)-A, she explained that she utilized a tracking system for evaluations and the directors had access to the spread sheet. She further stated the evaluations were "further behind than I would like to be." Employee date of hire and evaluation dates provided by facility were as follows: E1's evaluation was effective through 6/21/16 E2's evaluation was effective through 8/5/16 E3's evaluation was effective through 8/22/14 E4's evaluation was effective through 11/9/14 E5's evaluation was not received E6's evaluation was effective through 5/12/16 E7's evaluation was signed 2/26/15 E8's evaluation was not received E9's evaluation date was signed 3/5/15 E10's evaluation was dated 8/22/13 E11's dated was signed 3/20/15 E12's evaluation was effective through 3/15/16 E13's evaluation was effective through to 8/6/15 E14's evaluation was not received E15's evaluation was effective through 2/13/15	2 300	Committee, which meets Quarterly.	

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2 300	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The facility could ensure appropriate staff share responsibility for evaluating nursing assistant competency and evaluations reflect areas for improvement. The system for tracking could be reviewed by persons responsible. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for the provide services to minimize the risk for decreased range of motion (ROM) for 1 of 1 resident (R87) reviewed for ROM services. Findings include: R87 was reported to have a contracture to the right upper extremity (UE) following a stroke according to registered nurse (RN)-A on 9/20/16,	2 560	Resident R-87 Care Plan was updated reflecting the contracture and proper treatment was put into place for Nurses: To assure NAR has provided PROM to RUE twice a day starting 9/23/16. Nurse Managers will assess all other in house Residents for possible contractures; and if any found, either refer to Therapies, or an appropriate POC will be developed immediately. These assessments will be completed by	10/30/16

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2 560	Continued From page 5 at 10:40 a.m.. RN-A reported R87, however, did not utilize a splint, nor ROM services to the affected limb. On 9/21/16, at 11:38 a.m. R87 was in his room. No splint device was in use. When asked, R87 denied he utilized a splint or was provided exercises for the contracture to his right UE. Following the observation and interview with R87 at 11:48 a.m. RN-A explained the resident had utilized a splint in the past, but had refused to wear it during the day and then refused it "all together." RN-A verified R87 was not utilizing a splint nor did he receive ROM services from staff, explaining the resident "does it on his own." Staff were not monitoring or documenting any information related to R87's ROM or contracture status. A Restorative Nursing Assessment note dated 5/19/14, noted R87 was at risk for contractures and joint stiffness, and staff were advised to provide ROM to prevent contractures and joint stiffness to right upper and lower extremities. R87's care plan dated 4/16/15, indicated the resident was involved with the restorative nursing program and was assisted with walking. The care plan did not direct staff to provide ROM services or to apply a splint. An Order Communication Form dated 2/16/16, indicated a therapist recommended a hand brace for R87, but the R87 refused to wear it, so it was discontinued and staff were to "continue to monitor." A Restorative Nursing Assessment note dated 3/17/16, stated "discontinuation of restorative	2 560	10/17/16 Nurse Managers will monitor all residents with contractures at a minimum of quarterly and update Care plan as appropriate. Staffs were educated on the importance of ensuring Resident needs are entered on the Care plans; and that we are following each Individualized Resident Care Plan to meet the Resident needs DON will audit on a quarterly basis, that all residents with Contractures have proper POC in place; plus discuss her findings at our QA Committee meetings on a quarterly basis.	

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2 560	Continued From page 6	2 560		

programs related to non-ambulatory status and non-compliance. Will re-address with PT/OT [physical therapy/occupational therapy] as needed."

Neither the current Long Term Care Card or current Guideline For Daily Care sheet directed the NAs to provide exercises or ROM for R87.

On 9/22/16, at 7:53 a.m. a nursing assistant (NA)-G reported regarding R87's contracture that she "loosened it up" when providing morning cares, but she denied providing structured ROM services or documentation of completion.

During an interview at 7:58 a.m. the occupational therapist (OTR) explained the therapy staff had made a Soft Pro hand splint (used to treat moderate flexion contractures of wrist, hand and thumb). R87 began using the splint on 11/5/14, only wearing the splint at night per his choice. He started to refuse application of the splint towards the beginning of 2016, and consequently the device was discontinued on 2/16/16. She further explained R87 had received restorative ROM and ambulation services, but because the resident refused the ambulation services, the entire program was discontinued since two services were needed to fulfill the requirements of the facility's restorative nursing program. The OTR stated she would have expected nursing to continue to provide ROM when therapy services ended to ensure residents maintained their ROM status, particularly with hemiplegia.

On 9/22/16, at 9:04 a.m. RN-A stated ROM for R87 had not been put into the NA's tasks after the restorative program stopped. RN-A stated, "I would have expected this to be done. It falls under my jurisdiction. It wasn't done." She verified

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2 560	Continued From page 7 it should have been provided for a resident with hemiplegia. On 9/22/15, at 1:53 p.m. the director of nursing (DON) stated she would have expected when a resident had ROM limitations but had completed therapy, the resident would have been assessed and started on a restorative program to maintain their current status if services were deemed beneficial. The DON also stated she would have expected a care plan to include ROM, therapy and other directions on the care of a resident. The care plan should have been updated as needed to ensure a resident was getting the care they required. The facility's 7/1/16, ROM policy indicated the purpose for ROM "is to move the resident's joints through as full a range of motion as possible, maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent complications of mobility." A care plan policy was requested but not obtained. SUGGESTED METHOD OF CORRECTION: The facility could review care planning for residents who require ROM/splints. Persons responsible for care plan development could be educated. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		10/30/16

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2 895	Continued From page 8 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to minimize the risk for decreased range of motion (ROM) for 1 of 1 resident (R87) reviewed for ROM services. Findings include: R87 was reported to have a contracture to the right upper extremity (UE) following a stroke according to registered nurse (RN)-A on 9/20/16, at 10:40 a.m.. RN-A reported R87, however, did not utilize a splint, nor ROM services to the affected limb. On 9/21/16, at 11:38 a.m. R87 was in his room. No splint device was in use. When asked, R87 denied he utilized a splint or was provided exercises for the contracture to his right UE. Following the observation and interview with R87 at 11:48 a.m. RN-A explained the resident had	2 895	Resident R-87 Care Plan was updated reflecting the contracture and proper treatment was put into place for Nurses: To assure NAR has provided PROM to RUE twice a day starting 9/23/16. Nurse Managers will assess all other in house Residents for possible contractures; and if any found, either refer to Therapies, or an appropriate POC will be developed immediately. These assessments will be completed by 10/17/16 Nurse Managers will monitor all residents with contractures at a minimum of quarterly and update Care plan as appropriate. Staffs were educated on the importance of ensuring Resident needs are entered on the Care plans; and that we are following each Individualized Resident Care Plan to meet the Resident needs	

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2 895	Continued From page 9 utilized a splint in the past, but had refused to wear it during the day and then refused it "all together." RN-A verified R87 was not utilizing a splint nor did he receive ROM services from staff, explaining the resident "does it on his own." Staff were not monitoring or documenting any information related to R87's ROM or contracture status. A Restorative Nursing Assessment note dated 5/19/14, noted R87 was at risk for contractures and joint stiffness, and staff were advised to provide ROM to prevent contractures and joint stiffness to right upper and lower extremities. R87's care plan dated 4/16/15, indicated the resident was involved with the restorative nursing program and was assisted with walking. The care plan did not direct staff to provide ROM services or to apply a splint. An Order Communication Form dated 2/16/16, indicated a therapist recommended a hand brace for R87, but the R87 refused to wear it, so it was discontinued and staff were to "continue to monitor." A Restorative Nursing Assessment note dated 3/17/16, stated "discontinuation of restorative programs related to non-ambulatory status and non-compliance. Will re-address with PT/OT [physical therapy/occupational therapy] as needed." Neither the current Long Term Care Card or current Guideline For Daily Care sheet directed the NAs to provide exercises or ROM for R87. On 9/22/16, at 7:53 a.m. a nursing assistant (NA)-G reported regarding R87's contracture that	2 895	DON will audit on a quarterly basis, that all residents with Contractures have proper POC in place; plus discuss her findings at our QA Committee meetings on a quarterly basis.	

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2 895	Continued From page 10	2 895		

she "loosened it up" when providing morning cares, but she denied providing structured ROM services or documentation of completion.

During an interview at 7:58 a.m. the occupational therapist (OTR) explained the therapy staff had made a Soft Pro hand splint (used to treat moderate flexion contractures of wrist, hand and thumb). R87 began using the splint on 11/5/14, only wearing the splint at night per his choice. He started to refuse application of the splint towards the beginning of 2016, and consequently the device was discontinued on 2/16/16. She further explained R87 had received restorative ROM and ambulation services, but because the resident refused the ambulation services, the entire program was discontinued since two services were needed to fulfill the requirements of the facility's restorative nursing program. The OTR stated she would have expected nursing to continue to provide ROM when therapy services ended to ensure residents maintained their ROM status, particularly with hemiplegia.

On 9/22/16, at 9:04 a.m. RN-A stated ROM for R87 had not been put into the NA's tasks after the restorative program stopped. RN-A stated, "I would have expected this to be done. It falls under my jurisdiction. It wasn't done." She verified it should have been provided for a resident with hemiplegia.

On 9/22/15, at 1:53 p.m. the director of nursing stated she would have expected when a resident had ROM limitations but had completed therapy, the resident would have been assessed and started on a restorative program to maintain their current status if services were deemed beneficial.

The facility's 7/1/16, ROM policy indicated the

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2 895	Continued From page 11 purpose for ROM "is to move the resident's joints through as full a range of motion as possible, maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent complications of mobility." SUGGESTED METHOD OF CORRECTION: The facility could evaulate residents for the need for ROM/splints. An educational review of proper ROM technique could be presented. Residents who decline ROM/splints could be reassessed to increase compliance to minimize the risk for decline. Audits could be conducted and the results brought the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation interview, and document review, the facility failed to disinfect glucometers to minimize the risk of infection for 5 of 5 residents (R50, R128, R45, R158, R87) whose blood glucose monitoring was observed. This had potential to affect 19 other residents who utilized the shared glucometers. In addition, the facility failed to ensure proper handwashing technique was practiced for 1 of 1 resident (R115) who	21375	Professional Nurses were educated on the proper hand washing techniques immediately upon the discovery of the concern. Other facility staff were also educated on proper handwashing through In services/training Glucometers: On 9/21/16 Policy was reviewed and changes were made to reflect the proper cleaning procedure	10/30/16

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21375	Continued From page 12 utilized an indwelling catheter. Findings include: R50's glucose monitoring was observed on 9/20/16, at 7:24 a.m. performed by licensed practical nurse (LPN)-A. LPN-A washed her hands for five seconds and donned gloves. She then wiped the glucometer for five seconds with a Super Sani-Wipe, and then set the glucometer on the resident's bed. Following the blood sugar testing, LPN-A wiped the glucometer with another Super Sani-Wipe for three seconds and removed her gloves. LPN-A then washed her hands for five seconds and donned gloves. Using the same glucometer, R45's (R50's roommate) blood sugar was tested by LPN-A. Following the testing LPN-A wiped the glucometer for three seconds, removed her gloves, washed her hands for five seconds. LPN-A returned the glucometer to a a tray on the medication cart that contained opened gauze, lancets, and alcohol wipes. LPN-A was interviewed regarding the facility's procedure for cleaning glucometers on 9/20/16, at 7:32 a.m. LPN-A reported she had used Super Sani-Cloths to clean the glucometers for R50 and R45, and stated, "I just sort of wiped over the glucometer before and after. Glucometers are used for multiple patients. I washed my hands for two seconds and I should have for 15 seconds. I do not know how long I am supposed to wipe the glucometers" (after testing a resident's blood sugar). R128's blood sugar was tested on 9/20/16, at 8:02 a.m. performed by LPN-B. LPN-B brought the glucometer tray into R128's room and without washing hands, donned gloves. LPN-B then left R128's room wearing one glove and wiped the	21375	according to Manufactures Instructions. Nurses were educated with these changes in procedure immediately on 9/21/16. Individual Glucometers were also ordered for the majority of our Residents where appropriate. Nurse Managers will conduct 6 quarterly staff handwashing Audits for a total of 24 audits in the building each Quarter. DON will follow up on Audits and share the results to the Quality Assurance Committee meetings every Quarter.	

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glucometer with a Super Sani-Cloth for five seconds and placed it on the medication cart for five seconds. LPN-B then removed the glove, used hand sanitizer, and then placed the glucometer in the tray on the medication cart containing opened gauze, lancets, and alcohol wipes.

LPN-B was interviewed on 9/20/16, at 8:06 a.m. She stated, "The glucometers are shared, so we sanitize them before and after each use." LPN-B explained Super Sani-Cloths were used and the staff "just wipe them down and set them down to dry--and they dry quick--and then put it back" (in the tray). "I should've washed my hands before and after using the glucometer."

LPN-C stated in an interview on 9/20/16, at 8:27 a.m. regarding the facility's process for cleaning glucometers, "I would have to ask the night nurse about the glucometer cleaning protocol. We have one glucometer for all our residents. I don't know what the cleaning protocol is."

LPN-D performed blood sugar testing for R45 on 9/21/16, at 7:08 a.m. LPN-D obtained the tray containing glucose testing supplies into the resident's room. LPN-D set the tray on R45's bedside stand and the glucometer on the resident's bed. After testing R45's blood sugar, LPN-D removed her gloves, and without cleaning the glucometer, returned it to the tray containing supplies. She then removed her gloves and washed her hands. At 7:12 a.m. LPN-D removed the glucometer from the tray, wiped it briefly using a Super Sani-Cloth, and returned it to the tray. LPN-D explained, "We wipe the glucometer down with 'purple top wipe' and let it air dry. I left it on the med [medication] cart for five seconds and then put it back into tray. We use shared

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glucometers and have two glucometers in the med med cart on the Special Care unit."

R69's fungal rash care was observed on 9/21/16, at 7:21 a.m. LPN-D donned gloves and sprinkled power to R69's right armpit and rubbed it in with her gloved hand. LPN-D then removed her gloves and washed her hands for two seconds. Following the observation LPN-D confirmed she had not washed her hands thoroughly and stated, "I should wash hands for 30 seconds and I only did for two."

R87's blood glucose testing was observed on 9/21/16, at 7:37 a.m. performed by trained medication aide (TMA)-A. After gathering supplies, TMA-A placed the tray and glucometer on R87's bed. Following the blood sugar testing, TMA-A returned the glucometer to the medication cart, wiped the glucometer with a Dispatch wipe for 15 seconds, and 10 seconds later, returned it to the tray containing the supplies. TMA-A then explained, "We use the Dispatch Hospital Towels with Bleach. I wiped the glucometer down for 10 seconds and then let it air dry for 10 seconds and then put it in basket with the supplies." TMA-A confirmed the glucometers were shared, and she was responsible for testing six residents' blood sugars that day.

R158's glucose testing was observed on 9/21/16, at 9:09 a.m. performed by LPN-E. LPN-E set the tray containing supplies on R158's recliner and placed the testing strips on the resident's breakfast tray. After testing the resident's blood sugar, she returned the glucometer to the cart, wiped it with a Super Sani-Cloth for approximately 15 second, and returned it to the tray without allowing the glucometer to dry. Following the observation, LPN-E explained, "We use Super

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Sani-Cloths...Take one or two out and wash the glucometer for three to four seconds and put it back in the basket. I let it air dry for three seconds before putting it back in the basket." LPN-E acknowledges she had set the testing strips on R158's breakfast tray.

LPN-F was interviewed on 9/21/16, at 11:20 a.m. LPN-F stated the glucometers needed to be cleaned and disinfected using the appropriate wipes. Staff were supposed to wear gloves, pull out a wipe from the dispenser, wipe the device completely, usually for 15-20 seconds. The glucometer was to be completely dried on the medication cart on a clean towel prior to testing another resident using the shared glucometer. LPN-F then read the directions on the Super Sani-Cloth container which indicated, "Disinfect: unfold clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full 2 minutes, let air dry." LPN-F then stated, "I wipe the glucometer all around, and then set it down with clean towel and let it dry." LPN-F said glucometer training was provided at nursing meetings and new nurses were trained at orientation. Related policies and procedures were available on the computer. LPN-F stated, "We need to retrain staff, which I will do now and I will take the glucometers and clean them adequately."

RN-A was interviewed regarding glucometers on 9/21/16, at 11:31 a.m. She stated glucometers were to be thoroughly wiped using wipes between resident use, and the glucometers left to dry for one minute on the medication cart. RN-A said the wipes dried very quickly. She obtained Dispatch wipes from the cart and stated, "This product is not the same one I am used to using and I have not seen this one before." The instructions

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directed the user to wipe the surface with wipe until completely wet and let stand for one minute and allow to air dry.

On 9/21/16, at 11:58 a.m. the director of nursing (DON) stated staff was to utilize either Dispatch or Super Sani-Wipes. The facility's policy directed staff to wipe down glucometers in between uses, but did not indicate how long the glucometer should be left to dry. The DON verified the glucometers were stored with opened gauze and verified, "Currently we put it in the basket and we don't clean them properly because we don't have anything stating how long the glucometers should be cleaned or dried. I will go to the units, clean the glucometers properly, and will separate the supplies, and update the policy."

LPN-B was interviewed regarding hand washing on 9/22/16, at 1:06 p.m. She stated, "We can use hand sanitizer two to three times between hand washes. Hand washing is important before and after any wound cares, blood sugar checks, med passes. You should wash hands for about 20-30 seconds. I was trained right away when starting to work here and annually."

The DON stated on 9/23/16, at 10:23 a.m. she expected staff to wash their hands between resident cares. Additionally, staff were instructed to wash their hands upon entering and leaving a resident's room and during medication administration.

The facility's 9/1/11, Glucometer policy directs staff to disinfect all 'multiple use' glucometers between every resident use...Wipe glucometer with approved cleaning product--dispatch/Super Sani cloth. 4. Allow the unit to completely dry (2 minutes) based on the wipes manufacturer

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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instructions...The glucometer must be kept in separate area, must not be in with clean supplies used for the procedure. The nurse must complete the cleaning process before moving to another resident."

R115's cares were observed on 9/22/16, at 7:23 a.m. by nursing assistant (NA-F). NA-F donned gloves and assisted R115 to use a bedpan. Although R115 had an indwelling Foley catheter (a tube in the bladder to provide continuous urinary drainage), he had requested the bedpan for a bowel movement. After R115 reported he had unsuccessful results, NA-F removed the bedpan, covered R115 with a blanket, handed him the call light, removed her gloves and left the room touching the handle on both sides of the door. When asked why she did not wash her hands after removing her gloves, NA-F explained that she usually went across the hallway to wash her hands, "I know it's not a good thing to do. It's a bad habit."

At 7:30 a.m. registered nurse (RN)-A stated it was not acceptable to removed gloves and then leave the room without first washing hands. RN-A further explained, "It is taught not to use gloves in place of handwashing. When gloves comes off you need to wash your hands." RN-A verified R115 had a positive culture showing a urinary tract infection.

The facility's 8/1/16, General Guidelines For Hand Hygiene policy indicated "Hand-washing is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from he spread of infection...Before and after touching wounds of any kind...After touching any item or surface that may have been contaminated with

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21375	Continued From page 18 blood...Use friction while scrubbing hands vigorously for at least 20 seconds...." SUGGESTED METHOD OF CORRECTION: The facility could re-educate employees on proper handwashing, and conduct audits to ensure employee handwashing practices minimize the potential for the spread of infection. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		10/30/16

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21426	Continued From page 19 This MN Requirement is not met as evidenced by: Based on record review the facility failed to ensure symptom screening and tuberculin skin testing for 1 of 5 residents (R155) whose immunization records were reviewed. In addition the facility failed to ensure 2 of 5 employees (E1, E2) were properly screened for TB prior to working with residents as required. Findings include: R155 was admitted to the facility on 8/30/16. Immunization records revealed the facility staff had not screened the resident for potential symptoms of tuberculosis (TB) nor had the resident received tuberculin skin testing (TST) as required. Registered nurse (RN)-B explained on 9/23/16, at 12:03 p.m. that when a resident was newly admitted to the facility, they had physician orders for TB testing. If not, the nurse manager was responsible for contacting the physician regarding testing. During an interview on 9/23/16, at 10:20 a.m. the director of nursing confirmed R155 did not have a standing order for TST. Additionally, the facility staff had not completed symptom screening. The DON stated, "We missed this one and the resident did not get the first step TB screening until 9/22/16." E1's immunization records lacked evidence of TB symptom screening or step one and two TST. On 9/23/16, at 3:25 p.m. the administrator explained E1 reported she had provided the facility with a previous TST from another facility, but the facility	21426	The Resident (R155) who did not have documentation of a Tuberculin skin test; was completed on 10/8/16; All other residents were also audited to confirm completion of the TB Test. Nurse managers will monitor all new admissions to verify that the test are completed. DON will audit all new admissions each quarter to confirm compliance and report to the QA committee quarterly. Employee # E1 was removed from the floor immediately and directed to obtain a chest x-ray, which was inconclusive; blood workup was drawn and results were negative; Employee was restored to active work status; Employee # E2 will be completed by:10/30/16 HR will audit all new employees to ensure TB tests are completed according to our Policy and State Regulations. HR will then bring Audit findings to QA Committee on a quarterly base.	

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21426	Continued From page 20 could not provide the records. E2's immunization records showed that although symptom screening was completed on 6/1/16, and the first step TST was completed on 6/3/16, the records lacked evidence the second step TST had been administered and read as required. The administrator stated on 9/23/16, at 4:20 p.m. E2 should have had the second step administered prior to the date of the interview. SUGGESTED METHOD OF CORRECTION: The facility could review/develop their system for ensuring timely and appropriate TB immunizations to residents and employees, and conduct education with the appropriate employees to ensure implementation. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the	21990		10/30/16

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reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State agency (SA) for by 6 of 7 residents (R17, R39, R61, R66, R129, R157) who were reviewed for abuse prohibition. This also potentially affected all 90 residents residing in the facility.

Findings include:

The facility's Vulnerable Adult Reporting Tool revealed the following:

1. R66 had a left femoral neck fracture; the time of the incident was 4:00 p.m. on 7/17/16. The event was reported to the Minnesota Department of Health (MDH) by licensed social worker (LSW)-A on 7/18/16. The investigative report (7/18/16) indicated, "Social Worker, DON [director of nursing], and administrator notified within 24 hours."

2. R39 had a physical injury that was not reasonably explained with the date and time of the incident "unknown." The incident report was completed 8/9/16. The event was reported to MDH by registered nurse (RN)-C on 8/10/16. The investigative report (8/10/16) indicated, "DON, administrator were updated immediately."

3. R17 had physical injury that could not be

The Vulnerable Adult reporting Policy was updated to reflect the Minnesota language of reporting “Immediately” to SA (CEP) and Administrator; eliminating the language of “no later than 24 hours” as stated in the Federal Language. A Copy of the new Policy was given to the Survey team on 9/22/16.
Nurse Managers and other key staff were educated immediately on the States interpretations/expectations, with the new Policy taking effect 9/22/16.
Remaining Staff were educated through In-services/training regarding the importance of reporting any potential or suspicious events as described in the policy “immediately” to their supervisor or the SA (CEP) and Administrator. Training was also provided to staff on what are Reportable events as described by State and Federal Regulations; our internal investigation process, and the follow up requirement of submitting report to SA (CEP) within 5 days.
Social Service will audit future Reportable events as to the timeliness of being reported to the SA (CEP) and present those audit findings to our QA Committee on a quarterly basis.

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reasonably explained dated 3/24/16 with the date and time on the report "unknown." The event was reported to MDH by licensed practical nurse (LPN)-G on 3/25/16. The record did not indicate the administrator was immediately notified.

4. R61 had an event reported to MDH on 8/27/16. The date and time on the incident report was 8/27/16, at 12:58 a.m. The initial report document to the MDH, indicated a telephone call was made to the the Common Entry Point on 8/27/16 to report the event. The event was later reported to MDH by activity aide-A on 8/30/16, through the online reporting system. The investigative report (8/30/16) indicated "Families, DON, Charge Nurse, administrator, and MD [physician] notified of incident."

5. R129 had an abrasion/rug burn to the right side dated 4/4/16. The date and time on the incident report was "4/4/16 at 8:15 p.m. The event was reported to MDH by the LSW-A on 4/5/16. The record did not indicate the administrator was immediately notified of the event.

6. R157 had physical injury that could not be reasonably explained. The date and time on the incident report was 10/24/16, at 5:10 a.m. There was no evidence who had reported the event or when it had been reported, as the pages were not included in the information provided by the facility. An Oracle email was dated 10/27/15, at 2:35 p.m. The record did not indicate the administrator was immediately notified of the event.

On 9/22/16, at 10:27 a.m. LSW-B stated that when an event was discovered, it was reported to the charge nurse, director of nursing, or administrator. "If it is something that we feel like

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21990	Continued From page 23 we need to report right away, we will fill out an incident report and submit to MDH within the 24 hours during the weekend...We will bring the incident reports to our interdisciplinary team meeting [IDT] and we will discuss it further. At that point, the team will decide to report Vulnerable Adult issues within the 24 hours to the Department of Health." LSW-B explained the facility staff often did not report "immediately" as the facility policy indicated they had up to 24 hours, and they reported within that timeframe. Later that day at 12:22 p.m. LSW-B stated in an interview regarding R17 that a nurse had reported the event by telephone on 8/27/16, and "It was then completed online on 8/30/16." LSW-B reiterated they were following the policy that they were to report "no longer than 24 hours from the time initial knowledge that the incident occurred has been received." The DON stated in an interview on 9/22/16, at 10:30 a.m. events needed "to be reported to [facility] staff immediately, but the actual report to the MDH can be up to 24 hours in time." The DON further explained the charge nurse was to be informed of all events, including during the night. The charge nurse then determined whether the situation was "reportable" and "may" call the DON or administrator. The event reports were filled out by the nurse and reporting made to MDH if it was determined to be a reportable situation. The DON reviewed R157, R129 and R61's events and verified none of the situations were immediately reported using the online reporting system as required. She explained that there had been confusion regarding the required time frame for reporting and whether the facility had 24 hours to report. LSW-A explained on 9/22/16, at 12:38 p.m.	21990		

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21990	Continued From page 24 facility staff followed their policy and procedure which indicated they had up to 24 hours to report to the MDH. Licensed practical nurse (LPN)-C stated on 9/22/16, at 2:01 p.m. if an event happened on the weekend, "we would report on it first thing Monday morning to the IDT team." If it was a fall with an injury, they informed LSW-A. "If we felt it was warranted to continue with the process and report it we would during the weekend." The administrator stated in an interview on 9/23/16, at 8:31 a.m. he was to be informed of any events such as falls, someone who needed outside intervention or suspicious events that may be reportable immediately. He evaluated the facts of the situation and them they made a decision about reporting to MDH at that time. If it was reportable, the registered nurse (RN) supervisor "should report it." The administrator said they could contact him at anytime, 24 hours a day. He explained they would immediately remove any staff suspected or involved in a situation. The facility's undated Vulnerable Adult Reporting Tool reviewed on 9/23/16 indicated "*** If any of the above potential reportable incidents occur Administrator must be notified immediately, but no later than 24 hours ***." The facility's 3/30/16, Vulnerable Adult Report policy indicated, "Immediately is defined as: as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received...The Administrator and the Director of Nursing will be notified on any unknown injuries within 24 hours of onset...Reportable incidents must also be	21990		

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21990	Continued From page 25 electronically sent to the Minnesota Department of Health with 24 hours of the incidents discovery as required at 42 CFR 483.13 (C) (2) [Centers for Medicare and Medicaid Services regulatory reference]." SUGGESTED METHOD OF CORRECTION: Policies could be updated to reflect immediate reporting to the SA and administrator as required. Appropriate staff who immediately learned of potentially reportable incidents could also immediately report to the SA as required. The administrator could complete this or provide this direction to the person immediately reporting to the administrator to ensure this was completed. Following the report, the administrator, director of nursing, and licensed social worker could proceed with the investigation. Re-education could be provided. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.	22000		10/30/16

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22000	Continued From page 26 (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the	22000	Individual Residents events found not in	

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22000	Continued From page 27 facility failed to develop and operationalize abuse prohibition policies that included immediately reporting of allegations to the administrator and designated State agency (SA) for 6 of 7 residents (R17, R39, R61, R66, R129, R157), and potentially affecting all 90 residents residing in the facility. Findings include: The facility's undated Vulnerable Adult Reporting Tool reviewed on 9/23/16 indicated "*** If any of the above potential reportable incidents occur Administrator must be notified immediately, but no later than 24 hours ***." The facility's 3/30/16, Vulnerable Adult Report policy indicated, "Immediately is defined as: as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received...The Administrator and the Director of Nursing will be notified on any unknown injuries within 24 hours of onset...Reportable incidents must also be electronically sent to the Minnesota Department of Health with 24 hours of the incidents discovery as required at 42 CFR 483.13 (C) (2) [Centers for Medicare and Medicaid Services regulatory reference]." The facility's Vulnerable Adult Reporting Tool revealed the following: 1. R66 had a left femoral neck fracture; the time of the incident was 4:00 p.m. on 7/17/16. The event was reported to the Minnesota Department of Health (MDH) by licensed social worker (LSW)-A on 7/18/16. The investigative report (7/18/16) indicated, "Social Worker, DON [director of nursing], and administrator notified	22000	Compliance were reviewed by the Management team. The Vulnerable Adult reporting Policy was updated to reflect the Minnesota language of reporting “Immediately” to SA (CEP) and Administrator; eliminating the language of “no later than 24 hours” as stated in the Federal Language. A Copy of the new Policy was given to the Survey team on 9/22/16. Nurse Managers and other key staff were educated immediately on the States interpretations/expectations, with the new Policy taking effect 9/22/16. Remaining Staff were educated through In-services/training regarding the importance of reporting any potential or suspicious events as described in the policy “immediately” to their supervisor or the SA (CEP) and Administrator. Training was also provided to staff on what are Reportable events as described by State and Federal Regulations; our internal investigation process, and the follow up requirement of submitting report to SA (CEP) within 5 days. Social Service will audit future Reportable events as to the timeliness of being reported to the SA (CEP) and present those audit findings to our QA Committee on a quarterly basis.	

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within 24 hours."

2. R39 had a physical injury that was not reasonably explained with the date and time of the incident "unknown." The incident report was completed 8/9/16. The event was reported to MDH by registered nurse (RN)-C on 8/10/16. The investigative report (8/10/16) indicated, "DON, administrator were updated immediately."

3. R17 had physical injury that could not be reasonably explained dated 3/24/16 with the date and time on the report "unknown." The event was reported to MDH by licensed practical nurse (LPN)-G on 3/25/16. The record did not indicate the administrator was immediately notified.

4. R61 had an event reported to MDH on 8/27/16. The date and time on the incident report was 8/27/16, at 12:58 a.m. The initial report document to the MDH, indicated a telephone call was made to the the Common Entry Point on 8/27/16 to report the event. The event was later reported to MDH by activity aide-A on 8/30/16, through the online reporting system. The investigative report (8/30/16) indicated "Families, DON, Charge Nurse, administrator, and MD [physician] notified of incident."

5. R129 had an abrasion/rug burn to the right side dated 4/4/16. The date and time on the incident report was "4/4/16 at 8:15 p.m. The event was reported to MDH by the LSW-A on 4/5/16. The record did not indicate the administrator was immediately notified of the event.

6. R157 had physical injury that could not be reasonably explained. The date and time on the incident report was 10/24/16, at 5:10 a.m. There was no evidence who had reported the event or

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME	611 WEST MAIN STREET BELLE PLAINE, MN 56011

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when it had been reported, as the pages were not included in the information provided by the facility. An Oracle email was dated 10/27/15, at 2:35 p.m. The record did not indicate the administrator was immediately notified of the event.

On 9/22/16, at 10:27 a.m. LSW-B stated that when an event was discovered, it was reported to the charge nurse, director of nursing, or administrator. "If it is something that we feel like we need to report right away, we will fill out an incident report and submit to MDH within the 24 hours during the weekend...We will bring the incident reports to our interdisciplinary team meeting [IDT] and we will discuss it further. At that point, the team will decide to report Vulnerable Adult issues within the 24 hours to the Department of Health." LSW-B explained the facility staff often did not report "immediately" as the facility policy indicated they had up to 24 hours, and they reported within that timeframe. Later that day at 12:22 p.m. LSW-B stated in an interview regarding R17 that a nurse had reported the event by telephone on 8/27/16, and "It was then completed online on 8/30/16." LSW-B reiterated they were following the policy that they were to report "no longer than 24 hours from the time initial knowledge that the incident occurred has been received."

The DON stated in an interview on 9/22/16, at 10:30 a.m. events needed "to be reported to [facility] staff immediately, but the actual report to the MDH can be up to 24 hours in time." The DON further explained the charge nurse was to be informed of all events, including during the night. The charge nurse then determined whether the situation was "reportable" and "may" call the DON or administrator. The event reports were filled out by the nurse and reporting made to

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22000	Continued From page 30 MDH if it was determined to be a reportable situation. The DON reviewed R157, R129 and R61's events and verified none of the situations were immediately reported using the online reporting system as required. She explained that there had been confusion regarding the required time frame for reporting and whether the facility had 24 hours to report. LSW-A explained on 9/22/16, at 12:38 p.m. facility staff followed their policy and procedure which indicated they had up to 24 hours to report to the MDH. Licensed practical nurse (LPN)-C stated on 9/22/16, at 2:01 p.m. if an event happened on the weekend, "we would report on it first thing Monday morning to the IDT team." If it was a fall with an injury, they informed LSW-A. "If we felt it was warranted to continue with the process and report it we would during the weekend." The administrator stated in an interview on 9/23/16, at 8:31 a.m. he was to be informed of any events such as falls, someone who needed outside intervention or suspicious events that may be reportable immediately. He evaluated the facts of the situation and them they made a decision about reporting to MDH at that time. If it was reportable, the registered nurse (RN) supervisor "should report it." The administrator said they could contact him at anytime, 24 hours a day. He explained they would immediately remove any staff suspected or involved in a situation. SUGGESTED METHOD OF CORRECTION: Policies could be updated to reflect immediate reporting to the SA and administrator as required. Appropriate staff who immediately learned of	22000		

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22000	Continued From page 31 potentially reportable incidents could also immediately report to the SA as required. The administrator could complete this or provide this direction to the person immediately reporting to the administrator to ensure this was completed. Following the report, the administrator, director of nursing, and licensed social worker could proceed with the investigation. Re-education could be provided. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections.	23010		10/23/16

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23010	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 1 resident (R41) reviewed for environmental concerns. In addition, call lights in the memory care unit were not functioning when tested, which had the potential to affect 8 of 28 residents (R5, R30, R45, R73, R85, R95, R103, R138) who were capable of using the call light. Findings include: R41's bathroom call light was not present/available on 9/20/16, at 10:49 a.m. R41 explained, "It has been gone awhile. One night I was up and was going to use it and it was not there." She did not recall how long it had been missing. Licensed practical nurse (LPN)-C was then asked to come to R41's bathroom. LPN-C verified the call light was not present in the resident's bathroom, and stated she would address the issue with maintenance staff immediately. On 9/21/16, at 12:30 p.m. LPN-C reported R41's call light had been missing since 9/15/16, nearly a week prior. LPN-C said the maintenance man went to R41's bathroom to repair the toilet. The call light was on the back of the toilet tank. "He moved it to the plumbing cart to fix the toilet and forgot to put it back where he found it." She further explained that the facility had met and were working on a plan to prevent the problem from happening again. A letter was to be provided with staffs' paychecks on 9/23/16 asking staff to check for the presence and operation of the call	23010	Call Light was immediately reinstalled in R 41 Residents bathroom at time of Survey. A check was also completed for call lights in all other Resident rooms and bathrooms during the week of survey. No others were found missing. Call light system in SCR (Memory Care Unit) was reset within 12 minutes of the system going down. Evidence was obtained through a computer generated printout of call light activity on this Unit, and was provided to the Surveyor prior to Exit, as was a copy of our Policy regarding what staff are to do when the call lights do go down. The Policy requires checking on all Residents who cannot, or won't, leave their room, every 15 minutes. All other residents will be moved to common areas to be monitored. Staff were re-educated on our Policy of what to do when call lights go down through In-service training. All room and bathroom call lights will be visibly checked on a daily bases when rooms are cleaned by housekeeping. They (housekeeping) will also do checks on all Call lights on a monthly basis consisting of actually testing each light, assuring they are being activated and displayed in the hallway. Results of the daily and monthly checks will be reported to the QA Committee on a Quarterly basis.	

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lights. In addition, they would continue with monthly call light audits.

On 9/23/16, at 7:26 a.m. the campus director of environmental services (DES) stated a maintenance employee had removed the resident call light from the bathroom, which was later found on a cart. He explained that all the staff were to watch for call light function. Problems could be reported using a work order on any of the kiosks or computers. He explained they would continue to do the monthly safety checks. The last monthly safety inspection related to call lights was completed on 8/12/16.

R154's call light was not working when tested on 9/19/16, at 7:11 p.m. The problem was immediately reported licensed practical nurse (LPN)-F. LPN-F checked the call system and confirmed that actually the whole call light system on the memory care unit was not working. (The system from resident rooms and toilet/bathrooms to the nurse station; and to the nurse/ nursing assistant pagers.) LPN-F stated, "I am not sure what time the system fell. I will call IT [Information Technology] right away to get it fixed." On 9/23/16, at 12:53 p.m. LPN-F stated, "I do not recall if I answered any call lights [on 9/19/16] after lunch. It is the day shift housekeeper's assignment to walk around and check whether the call lights system is functioning or not. I am not sure if the housekeeper had checked the call lights that day. I assume she might have done some kind of check." LPN-F identified eight residents would have been capable of using their call lights on the unit.

On 9/23/16, at 1:37 p.m. the administrator stated, "I expect staff to do 15 minute checks. We also have a plan to upgrade the call system

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on the memory care unit. It has a software problem and it is outdated. Its needs to be upgraded."

The facility's Call Light System Failure policy developed 9/23/16, indicated "It is the policy of the Lutheran Home To provide a safe environment for all residents...All resident/staff will be immediately informed of call light system outage."

SUGGESTED METHOD OF CORRECTION: A system for checking call light function could be developed and appropriate staff trained. Audits could be conducted and the results brought to the quality committee for review.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.