DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: CZEB
1. MEDICARE/MEDICAID PROVIDI (L1) 245590 2.STATE VENDOR OR MEDICAID N (L2) 751243100	ER NO.	3. NAME AND AE (L3) LUTHERAN (L4) 611 WEST M (L5) BELLE PLA	DRESS OF FAC N HOME IAIN STREE	CILITY	TE SURVEY AGENCY (L6) 56011	Facility ID: 00605 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 5. EFFECTIVE DATE CHANGE OF ((L9) 	OWNERSHIP	7. PROVIDER/SU 01 Hospital	· ·	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
	2/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 97 (L37) (L38) 16. STATE SURVEY AGENCY REM	97 (L18) 97 (L17) OWN 19 SNF (L39)	B. Not in Compl Requirements ICF (L42)	nce With equirements e Based On: ccceptable POC liance with Progr and/or Applied V IID (L43)	am Waivers:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	
Lisa Hakanson, HFE NE			2/02/2017	(L19)	Mark Meath, E	01/25/2017 (L20)
PA	RT II - TO BE	COMPLETED E	BY HCFA RE	EGIONAI	COFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBIL X 1. Facility is Eligible to F 2. Facility is not Eligible 	Participate		PLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/01/1992	BEGINNINC	6 DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	e
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
(L27)	-	n of Admissions: Ispension Date:	(L44)			07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL	DATE		
	(L32)	11/18/2016		(L33)	DETERMINATION APPE	ROVAL

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 determined 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.

Lutheran Home December 2, 2016 Page 2

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

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			DATE OF REVISIT	
245590 _{Y1}	A. Building B. Wing	Y2	11/22/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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).

ITEI	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0225	Correction	ID Prefix F	0226		Correction	ID Prefix	F0279		Correction
Reg. #	483.13(c)(1)(ii)-(iii - (4)), (c)(2) Completed	Reg. #	33.13(c	:)	Completed	Reg. #	483.20(d), 483.20(k))(1)	Completed
LSC		10/30/2016	LSC _			10/30/2016	LSC			10/30/2016
ID Prefix	F0318	Correction	ID Prefix F	0441		Correction	ID Prefix	F0463		Correction
Reg. #	483.25(e)(2)	Completed	48 Reg. #	33.65		Completed	Reg. #	483.70(f)		Completed
LSC		10/30/2016	LSC _			10/30/2016	LSC			10/23/2016
ID Prefix	F0497	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.75(e)(8)	Completed	Reg. #			Completed	Reg. #			Completed
LSC		10/30/2016	LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC _				LSC			
ID Prefix		Correction	ID Prefix _			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC _				LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) GL/KJ	date 12/02/20	16	SIGNATURE OF SU	irveyor 282	230		date 11/22	2/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/23/2016		DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					VES	в 🔲 NO	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION D						
IDENTIFICATION NUMBER	A. Building 02 - 1961, 1970, 1998 ADDITIONS	3				
245590 _{Y1}	B. Wing	ing Y2				
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).

ITE	ITEM DATE		ITEM	DATE	ITEM DATE		
Y4		Y5	Y4	Y5	Y4	Y5	
ID Prefix Reg. # LSC	NFPA 101 K0025	Correction Completed 09/22/2016	ID Prefix Reg. # NFPA 10 LSC K0062	Correction Completed 09/22/2016	ID Prefix Reg. # LSC	Correction Completed	
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #	Correction Completed	ID Prefix Reg. #	Correction Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg. # LSC		Completed	Reg. # LSC	Completed	Reg. # LSC	Completed	
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	date 12/02/2016	SIGNATURE OF SURVEYOR	7008	date 10/31/2016	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016		CHECK FOR J UNCORRECT					



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,

ate Comston

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		DATE OF REVIS	IT
00605	B. Wing	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).

ITE	Μ		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20300		Correction	ID Prefix	20560		Correction	ID Prefix	20895		Correction
Reg. #	MN Rule 4658.01	05	Completed	Reg. #	MN Rul Subp. 2	e 4658.0405	Completed	Reg. #	MN Rule 4658.052 Subp. 2.B	5	Completed
LSC			10/23/2016	LSC			10/23/2016	LSC			10/23/2016
ID Prefix	21375		Correction	ID Prefix	21426		Correction	ID Prefix	21990		Correction
Reg. #	MN Rule 4658.08 Subp. 1	00	Completed	Reg. #	MN St. Subd. 3	Statute 144A.04	Completed	Reg. #	MN St. Statute 626 Subd. 4	.557	Completed
LSC			10/23/2016	LSC			10/23/2016	LSC			10/23/2016
ID Prefix	22000		Correction	ID Prefix	23010		Correction	ID Prefix			Correction
Reg. #	MN St. Statute 6 Subd. 14 (a)-(c)	26.557	Completed	Reg. #	MN Rul	e 4658.4635 A	Completed	Reg. #			Completed
LSC			10/23/2016	LSC			10/23/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
REVIEWE		REVIEWE (INITIALS		date 12/02/2	2016	SIGNATURE OF S		8230		date 11/2	2/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO	OMPLETED	ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							
						Page 1 of 1			EVENT ID:	CZEB12	

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: CZEB		
	PART I -	TO BE COMPL	ETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00605		
1. MEDICARE/MEDICAID PROVIDER (L1) 245590	NO.	3. NAME AND AD (L3) LUTHERAN		CILITY		 TYPE OF ACTION: <u>2</u> (L8) Initial 2. Recertification 		
2.STATE VENDOR OR MEDICAID NO (L2) 751243100		(L4) 611 WEST M (L5) BELLE PLA		Г	(L6) 56011	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 09/23/2	016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit		
		_			3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	97 (L18)	1. A0	cceptable POC		4. 7-Day RN (Rural SN	—		
13.Total Certified Beds	97 (L17)	X B. Not in Com	pliance with Prog and/or Applied V		5. Life Safety Code	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOW	N	Requirements	and/or Applied V	valvels.	* Code: B * 15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
97	19 01 1							
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Douglas Stevens, HFE	NEII	10	0/21/2016	(L19)	Mark Meath, Enforcement Specialist 11/18/2016 (L20)			
PAR	TII - TO BE	COMPLETED B	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILIT			PLIANCE WITH TS ACT:	I CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUNTARY		
01/01/1992					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination	e		
25. LTC EXTENSION DATE:		VE SANCTIONS			04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(1.4.4)		04-0ther reason for windrawar	07-Provider Status Change 00-Active		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APPE	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: CZEB PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Facility ID: 00605

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 surve 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:

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

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

<u>Substandard Quality of Care</u> - 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;

Appeal Rights - 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)

Lutheran Home October 10, 2016 Page 3

• 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 <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this

Lutheran Home October 10, 2016 Page 4

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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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

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

	-	AND HUMAN SERVICES			-	APPROVED
		& MEDICAID SERVICES	-		<u> </u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245590	B. WING _		09 /	/23/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
F 225 SS=E	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substare gulations has beer your verification. An extended survey Minnesota Departm An investigation of completed at the tir was found not subs 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/IND The facility must no been found guilty of mistreating residen had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with y was also conducted by the nent of Health on 9/23/16. complaint H5590022 was also ne of the standard survey and stantiated. (c)(2) - (4) PORT DIVIDUALS of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry	F 22	25		10/30/16
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 10/21/2016

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245590	B. WING			09/2	23/2016
NAME OF I	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				61	11 WEST MAIN STREET		
LUTHER	AN HOME			В	ELLE PLAINE, MN 56011		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(AS) COMPLETION DATE
F 225		-	F 2	25			
		ent, neglect, or abuse,					
		unknown source and					
		resident property are reported administrator of the facility and					
		accordance with State law					
		procedures (including to the					
	State survey and ce						
		we evidence that all alleged					
		ughly investigated, and must ential abuse while the					
	investigation is in p						
	invooligation io in p	10g1000.					
		vestigations must be reported					
	to the administrator						
		to other officials in accordance					
		uding to the State survey and) within 5 working days of the					
		alleged violation is verified					
		ive action must be taken.					
	This REQUIREMEN	NT is not met as evidenced					
		v and document review, the			Individual Residents events found n	not in	
		rediately report allegations of			Compliance were reviewed by the		
		nated State agency (SA) for by			Management team.		
	6 of 7 residents (R1	17, R39, R61, R66, R129,			The Vulnerable Adult reporting Polic		
		viewed for abuse prohibition.			updated to reflect the Minnesota lan	0 0	
		y affected all 90 residents			of reporting "Immediately" to SA (CE	:P)	
	residing in the facili	ιγ.			and Administrator; eliminating the language of "no later than 24 hours"	26	
	Findings include:				stated in the Federal Language. A C the new Policy was given to the Surv	opy of	
	The facility's Vulner	able Adult Reporting Tool			team on 9/22/16.	- ,	
	revealed the followi				Nurse Managers and other key staff		
					educated immediately on the States		
	I. HOO NAD A LETT 1	femoral neck fracture; the time			interpretations/expectations, with the	e new	

Facility ID: 00605

If continuation sheet Page 2 of 29

PRINTED: 10/21/2016 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 | Continued From page 2 F 225 of the incident was 4:00 p.m. on 7/17/16. The Policy taking effect 9/22/16. event was reported to the Minnesota Department Remaining Staff were educated through of Health (MDH) by licensed social worker In-services/training regarding the importance of reporting any potential or (LSW)-A on 7/18/16. The investigative report (7/18/16) indicated, "Social Worker, DON suspicious events as described in the [director of nursing], and administrator notified policy "immediately" to their supervisor or within 24 hours." the SA (CEP) and Administrator. Training was also provided to staff on what are 2. R39 had a physical injury that was not Reportable events as described by State reasonably explained with the date and time of and Federal Regulations; our internal the incident "unknown." The incident report was investigation process, and the follow up completed 8/9/16. The event was reported to requirement of submitting report to SA MDH by registered nurse (RN)-C on 8/10/16. The (CEP) within 5 days. Social Service will audit future Reportable investigative report (8/10/16) indicated, "DON, administrator were updated immediately." events as to the timeliness of being reported to the SA (CEP) and present 3. R17 had physical injury that could not be those audit findings to our QA Committee reasonably explained dated 3/24/16 with the date on a quarterly basis. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 10/21/2016

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245590	B. WING		09/:	23/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	The record did not immediately notified 6. R157 had phys reasonably explain incident report was was no evidence w when it had been re- included in the infor An Oracle email wa The record did not immediately notified On 9/22/16, at 10:2 when an event was the charge nurse, or administrator. "If it we need to report r incident report and hours during the we incident reports to or meeting [IDT] and w that point, the team Vulnerable Adult iss Department of Hea facility staff often di the facility policy ind hours, and they rep Later that day at 12 interview regarding the event by teleph then completed onl reiterated they were were to report "no I time initial knowled has been received.	indicate the administrator was d of the event. sical injury that could not be ed. The date and time on the 10/24/16, at 5:10 a.m. There tho had reported the event or eported, as the pages were not rmation provided by the facility. as dated 10/27/15, at 2:35 p.m. indicate the administrator was d of the event. 27 a.m. LSW-B stated that d discovered, it was reported to director of nursing, or is something that we feel like ight away, we will fill out an submit to MDH within the 24 eekendWe will bring the our interdisciplinary team we will discuss it further. At n will decide to report sues within the 24 hours to the lith." LSW-B explained the id not report "immediately" as dicated they had up to 24 ported within that timeframe. 2:22 p.m. LSW-B stated in an R17 that a nurse had reported one on 8/27/16, and "It was line on 8/30/16." LSW-B e following the policy that they onger than 24 hours from the ge that the incident occurred				

Facility ID: 00605

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245590	B. WING	i		09/:	23/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME				611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	10:30 a.m. events r [facility] staff immed the MDH can be up DON further explain be informed of all e night. The charge n the situation was "n DON or administrat filled out by the nur MDH if it was deter situation. The DON R61's events and v were immediately n reporting system as there had been con time frame for repo had 24 hours to rep LSW-A explained of facility staff followed which indicated the to the MDH. Licensed practical n 9/22/16, at 2:01 p.n weekend, "we woul Monday morning to with an injury, they was warranted to cl report it we would of The administrator s 9/23/16, at 8:31 a.n any events such as outside intervention may be reportable if facts of the situation decision about report	needed "to be reported to diately, but the actual report to o to 24 hours in time." The ned the charge nurse was to events, including during the nurse then determined whether reportable" and "may" call the tor. The event reports were se and reporting made to rmined to be a reportable I reviewed R157, R129 and rerified none of the situations eported using the online s required. She explained that offusion regarding the required porting and whether the facility	F2	225			

		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245590	B. WING			09/2	23/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				I1 WEST MAIN STREET ELLE PLAINE, MN 56011		
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F 225	said they could con a day. He explained	ige 5 report it." The administrator tact him at anytime, 24 hours d they would immediately uspected or involved in a	F 2	225			
	Tool reviewed on 9/ the above potential	ed Vulnerable Adult Reporting /23/16 indicated "*** If any of reportable incidents occur be notified immediately, but urs ***."					
F 226 SS=F	policy indicated, "Im soon as possible, b from the time initial occurred has been and the Director of unknown injuries w onsetReportable electronically sent t of Health with 24 ho as required at 42 C Medicare and Medi reference]." 483.13(c) DEVELO	incidents must also be to the Minnesota Department burs of the incidents discovery FR 483.13 (C) (2) [Centers for caid Services regulatory P/IMPLMENT	F 2	226			10/30/16
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.					
	by:	NT is not met as evidenced and document review, the			The Vulnerable Adult reporting Poli	icy	

Facility ID: 00605

If continuation sheet Page 6 of 29

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY
	IDENTIFICATION IDENTIFICATION NUMBER.			IG		
		245590	B. WING _			23/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	θE	
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 226	facility failed to dev prohibition policies reporting of allegati designated State ag (R17, R39, R61, R6 potentially affecting facility. Findings include: The facility's undate Tool reviewed on 9/ the above potential Administrator must no later than 24 hou The facility's 3/30/1 policy indicated, "In soon as possible, b from the time initial occurred has been and the Director of unknown injuries w onsetReportable electronically sent t of Health with 24 hou as required at 42 C Medicare and Medi reference]." The facility's Vulner revealed the followi 1. R66 had a left fo of the incident was event was reported of Health (MDH) by (LSW)-A on 7/18/10	elop and operationalize abuse that included immediately ons to the administrator and gency (SA) for 6 of 7 residents 56, R129, R157), and all 90 residents residing in the ed Vulnerable Adult Reporting /23/16 indicated "*** If any of reportable incidents occur be notified immediately, but urs ***." 6, Vulnerable Adult Report mediately is defined as: as but no longer than 24 hours knowledge that the incident receivedThe Administrator Nursing will be notified on any ithin 24 hours of incidents must also be to the Minnesota Department ours of the incidents discovery FR 483.13 (C) (2) [Centers for caid Services regulatory	F 22	26 was updated to reflect the Mir language of reporting "Immed (CEP) and Administrator; elim language of "no later than 24 stated in the Federal Languag the new Policy was given to the team on 9/22/16. Nurse Managers and other kee educated immediately on the interpretations/expectations, w Policy taking effect 9/22/16. Remaining Staff were educated In-services/training regarding importance of reporting any po- suspicious events as describe policy "immediately" to their set the SA (CEP) and Administrate was also provided to staff on w Reportable events as describe and Federal Regulations; our investigation process, and the requirement of submitting rep (CEP) within 5 days. Social Service will audit future events as to the timeliness of reported to the SA (CEP) and those audit findings to our QA on a quarterly basis.	iately" to SA inating the hours" as le. A Copy of le Survey by staff were States with the new ed through the otential or ed in the upervisor or or. Training what are ed by State internal follow up ort to SA Reportable being present	

If continuation sheet Page 7 of 29

		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245590	B. WING			09/:	23/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	[director of nursing] within 24 hours." 2. R39 had a phys reasonably explained the incident "unknoi completed 8/9/16. T MDH by registered investigative report administrator were 3. R17 had physic reasonably explained and time on the rep reported to MDH by (LPN)-G on 3/25/16 the administrator w 4. R61 had an eve 8/27/16. The date at was 8/27/16, at 12:: document to the MI was made to the th 8/27/16 to report the reported to MDH by through the online r investigative report DON, Charge Nurs [physician] notified 5. R129 had an at side dated 4/4/16. T incident report was was reported to MD The record did not i immediately notified 6. R157 had phys	I, and administrator notified sical injury that was not ed with the date and time of wn." The incident report was The event was reported to nurse (RN)-C on 8/10/16. The (8/10/16) indicated, "DON, updated immediately." cal injury that could not be ed dated 3/24/16 with the date port "unknown." The event was y licensed practical nurse 5. The record did not indicate as immediately notified. ent reported to MDH on and time on the incident report 58 a.m. The initial report DH, indicated a telephone call e Common Entry Point on e event. The event was later y activity aide-A on 8/30/16, reporting system. The (8/30/16) indicated "Families, e, administrator, and MD of incident." brasion/rug burn to the right The date and time on the "4/4/16 at 8:15 p.m. The event DH by the LSW-A on 4/5/16. indicate the administrator was	F 2	226			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	тірі		FORM MB NO.	10/21/2016 APPROVED 0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245590	B. WING			09/2	23/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	incident report was was no evidence wi when it had been re- included in the infor An Oracle email wa The record did not i immediately notified On 9/22/16, at 10:2 when an event was the charge nurse, d administrator. "If it i we need to report ri- incident report and hours during the we incident reports to o meeting [IDT] and we that point, the team Vulnerable Adult iss Department of Hea facility staff often di the facility policy ind hours, and they rep Later that day at 12 interview regarding the event by telepho- then completed onl reiterated they were were to report "no lo time initial knowledgh has been received. The DON stated in 10:30 a.m. events r [facility] staff immed the MDH can be up DON further explain be informed of all e	10/24/16, at 5:10 a.m. There ho had reported the event or eported, as the pages were not mation provided by the facility. as dated 10/27/15, at 2:35 p.m. indicate the administrator was d of the event. 7 a.m. LSW-B stated that discovered, it was reported to lirector of nursing, or s something that we feel like ight away, we will fill out an submit to MDH within the 24 eekendWe will bring the our interdisciplinary team we will discuss it further. At will decide to report sues within the 24 hours to the lth." LSW-B explained the d not report "immediately" as dicated they had up to 24 orted within that timeframe. ::22 p.m. LSW-B stated in an R17 that a nurse had reported one on 8/27/16, and "It was ine on 8/30/16." LSW-B e following the policy that they onger than 24 hours from the ge that the incident occurred	F2	226			

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		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245590	B. WING			09/;	23/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME			-	11 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	the situation was "ro DON or administrat filled out by the nurs MDH if it was deter situation. The DON R61's events and v were immediately ro reporting system as there had been con- time frame for repo- had 24 hours to repo- was reportable in the supervisor "should said they could con- a day. He explained	eportable" and "may" call the tor. The event reports were se and reporting made to mined to be a reportable reviewed R157, R129 and erified none of the situations eported using the online s required. She explained that infusion regarding the required rig and whether the facility	F 2	26			

Facility ID: 00605

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 10 F 279 483.20(d), 483.20(k)(1) DEVELOP F 279 F 279 10/30/16 COMPRÉHENSIVE CARE PLANS SS=D 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 Resident R-87 Care Plan was updated review, the facility failed to develop a care plan for reflecting the contracture and proper the provide services to minimize the risk for treatment was put into place for Nurses: decreased range of motion (ROM) for 1 of 1 To assure NAR has provided PROM to resident (R87) reviewed for ROM services. RUE twice a day starting 9/23/16. Nurse Managers will assess all other in house Residents for possible Findings include: contractures; and if any found, either refer R87 was reported to have a contracture to the to Therapies, or an appropriate POC will right upper extremity (UE) following a stroke be developed immediately. These according to registered nurse (RN)-A on 9/20/16, assessments will be completed by at 10:40 a.m.. RN-A reported R87, however, did 10/17/16

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Facility ID: 00605

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PRINTED: 10/21/2016 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245590 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 Continued From page 11 F 279 not utilize a splint, nor ROM services to the Nurse Managers will monitor all residents affected limb. with contractures at a minimum of guarterly and update Care plan as On 9/21/16, at 11:38 a.m. R87 was in his room. appropriate. No splint device was in use. When asked, R87 Staffs were educated on the importance denied he utilized a splint or was provided of ensuring Resident needs are entered exercises for the contracture to his right UE. on the Care plans; and that we are following each Individualized Resident Following the observation and interview with R87 Care Plan to meet the Resident needs at 11:48 a.m. RN-A explained the resident had utilized a splint in the past, but had refused to DON will audit on a quarterly basis, that all wear it during the day and then refused it "all residents with Contractures have proper together." RN-A verified R87 was not utilizing a POC in place; plus discuss her findings at splint nor did he receive ROM services from staff, our QA Committee meetings on a explaining the resident "does it on his own." Staff quarterly basis. 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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 10/21/2016

		AND HUMAN SERVICES			FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY IPLETED
		245590	B. WING		09/:	23/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	programs related to non-compliance. W [physical therapy/or needed." Neither the current current Guideline F the NAs to provide On 9/22/16, at 7:53 (NA)-G reported res she "loosened it up cares, but she deni services or docume During an interview therapist (OTR) exp made a Soft Pro ha moderate flexion co thumb). R87 began only wearing the sp started to refuse ap the beginning of 20 device was disconti explained R87 had ambulation services refused the ambula program was disco were needed to fulf facility's restorative stated she would ha continue to provide ended to ensure re- status, particularly v On 9/22/16, at 9:04 R87 had not been the restorative prog	 a non-ambulatory status and /ill re-address with PT/OT ccupational therapy] as Long Term Care Card or for Daily Care sheet directed exercises or ROM for R87. a a.m. a nursing assistant garding R87's contracture that " when providing morning ed providing structured ROM entation of completion. at 7:58 a.m. the occupational plained the therapy staff had and splint (used to treat ontractures of wrist, hand and n using the splint on 11/5/14, plint at night per his choice. He opplication of the splint towards 16, and consequently the inued on 2/16/16. She further received restorative ROM and s, but because the resident attion services, the entire ntinued since two services fill the requirements of the nursing program. The OTR ave expected nursing to ROM when therapy services sidents maintained their ROM 	F 279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET BELLE PLAINE, MN 56011 09/23/2016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES			FORM	: 10/21/2016 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ODREFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x4) PREFIX TAG 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. F 279 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. He are the care of a resident. The care plan should have been updated as needed to ensure a resident was getting the care they required.	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
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 MOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION MOULD BE CAOSS-REFERENCED TO THE APPROPRIATE COMPLET DATE 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. F 279 F 279 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.			245590	B. WING _		09/	23/2016
BELLE PLAINE, MN 56011 YX4) 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 BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X3) COMPLET DATE 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. F 279 F 279 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.	NAME OF F	PROVIDER OR SUPPLIER	·•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE 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. F 279 F 279 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. F	LUTHER	AN HOME					
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.	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
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 318	under my jurisdictio it should have been hemiplegia. On 9/22/15, at 1:53 (DON) stated she w resident had ROM I therapy, the resider and started on a resider and started on a resider and started on a resider and started on a resider and other directions The care plan shou needed to ensure a they required. The facility's 7/1/16 purpose for ROM "in through as full a rar maintain joint mobil prevent contracture activity tolerance, resident, and A care plan policy w obtained. 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility with a limited range appropriate treatmer range of motion and	a provided for a resident with a provided for a resident with b p.m. the director of nursing yould have expected when a limitations but had completed nt would have been assessed storative program to maintain if services were deemed N also stated she would have an to include ROM, therapy s on the care of a resident. Id have been updated as a resident was getting the care a resident was getting the care b, ROM policy indicated the is to move the resident's joints nge of motion as possible, lity and muscle strength, es, increase strength and educe pain and prevent obility." was requested but not EASE/PREVENT DECREASE TION prehensive assessment of a a must ensure that a resident e of motion receives ent and services to increase d/or to prevent further		779		10/30/16

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					OMB NO.	APPROVED 0938-0391	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING			23/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 611 WEST MAIN STREET	ODE		
LUTHER	AN HOME			BELLE PLAINE, MN 56011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	Continued From pa	ge 14	F 3	18			
	This REQUIREMEN	NT is not met as evidenced					
	Based on observat review, the facility fa minimize the risk fo (ROM) for 1 of 1 re ROM services. Findings include: R87 was reported to right upper extremit according to registe at 10:40 a.m RN-A not utilize a splint, r affected limb. On 9/21/16, at 11:30 No splint device wa denied he utilized a exercises for the co Following the obser at 11:48 a.m. RN-A utilized a splint in th wear it during the d together." RN-A ver splint nor did he red explaining the resid were not monitoring information related status. A Restorative Nursi 5/19/14, noted R87 and joint stiffness, a	tion, interview and document ailed to provide services to r decreased range of motion esident (R87) reviewed for o have a contracture to the ty (UE) following a stroke ered nurse (RN)-A on 9/20/16, A reported R87, however, did for ROM services to the 8 a.m. R87 was in his room. s in use. When asked, R87 splint or was provided ontracture to his right UE. evation and interview with R87 explained the resident had he past, but had refused to ay and then refused it "all iffied R87 was not utilizing a seive ROM services from staff, ent "does it on his own." Staff g or documenting any to R87's ROM or contracture ng Assessment note dated was at risk for contractures and staff were advised to event contractures and joint		Resident R-87 Care Plan w reflecting the contracture an treatment was put into place To assure NAR has provided RUE twice a day starting 9/2 Nurse Managers will assess house Residents for possibl contractures; and if any four to Therapies, or an appropri- be developed immediately. assessments will be comple 10/17/16 Nurse Managers will monito with contractures at a minim quarterly and update Care p appropriate. Staffs were educated on the of ensuring Resident needs on the Care plans; and that following each Individualized Care Plan to meet the Resident DON will audit on a quarterly residents with Contractures POC in place; plus discuss I our QA Committee meetings quarterly basis.	d proper e for Nurses: d PROM to 23/16. all other in e nd, either refer ate POC will These ted by r all residents num of lan as importance are entered we are d Resident dent needs y basis, that all have proper her findings at		

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		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245590	B. WING _			09/	23/2016
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME			-	11 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	Continued From pa	ige 15	F 3	18			
	resident was involv program and was a	ted 4/16/15, indicated the ed with the restorative nursing assisted with walking. The care staff to provide ROM services					
	indicated a therapis for R87, but the R8	ication Form dated 2/16/16, st recommended a hand brace 7 refused to wear it, so it was taff were to "continue to					
	3/17/16, stated "dis programs related to non-compliance. W	ing Assessment note dated continuation of restorative o non-ambulatory status and /ill re-address with PT/OT ccupational therapy] as					
	current Guideline F	Long Term Care Card or or Daily Care sheet directed exercises or ROM for R87.					
	(NA)-G reported reg she "loosened it up cares, but she deni	a.m. a nursing assistant garding R87's contracture that " when providing morning ed providing structured ROM entation of completion.					
	therapist (OTR) exp made a Soft Pro ha moderate flexion co thumb). R87 began only wearing the sp started to refuse ap the beginning of 20	v at 7:58 a.m. the occupational plained the therapy staff had and splint (used to treat ontractures of wrist, hand and n using the splint on 11/5/14, plint at night per his choice. He oplication of the splint towards 16, and consequently the inued on 2/16/16. She further					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **611 WEST MAIN STREET** LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 318 Continued From page 16 F 318 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 441 483.65 INFECTION CONTROL. PREVENT F 441 10/30/16 SS=E SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 17 F 441 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 bv: Based on observation interview, and document Professional Nurses were educated on review, the facility failed to disinfect glucometers the proper hand washing techniques

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 B. WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 18 F 441 to minimize the risk of infection for 5 of 5 immediately upon the discovery of the residents (R50, R128, R45, R158, R87) whose concern. Other facility staff were also educated on proper handwashing through blood glucose monitoring was observed. This had potential to affect 19 other residents who utilized In services/training the shared glucometers. In addition, the facility Glucometers: On 9/21/16 Policy was failed to ensure proper handwashing technique reviewed and changes were made to was practiced for 1 of 1 resident (R115) who reflect the proper cleaning procedure utilized an indwelling catheter. according to Manufactures Instructions. Nurses were educated with these Findings include: changes in procedure immediately on 9/21/16. Individual Glucometers were also R50's glucose monitoring was observed on ordered for the majority of our Residents 9/20/16, at 7:24 a.m. performed by licensed where appropriate. practical nurse (LPN)-A. LPN-A washed her Nurse Managers will conduct 6 quarterly hands for five seconds and donned gloves. She staff handwashing Audits for a total of 24 then wiped the glucometer for five seconds with a audits in the building each Quarter. Super Sani-Wipe, and then set the glucometer on the resident's bed. Following the blood sugar DON will follow up on Audits and share testing, LPN-A wiped the glucometer with another the results to the Quality Assurance Super Sani-Wipe for three seconds and removed Committee meetings every Quarter. 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 alucometer 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

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		AND HUMAN SERVICES				FORM	: 10/21/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245590	B. WING	i		09/	23/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME			-	611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	sugar). R128's blood sugar 8:02 a.m. performe the glucometer tray washing hands, dor R128's room wearing glucometer with a S seconds and placed five seconds. LPN- used hand sanitizer glucometer in the tr containing opened wipes. LPN-B was intervie She stated, "The gl sanitize them befor explained Super Sa staff "just wipe them dryand they dry qu the tray). "I should'v and after using the LPN-C stated in an a.m. regarding the glucometers, "I wou about the glucomet one glucometer for what the cleaning p LPN-D performed to 9/21/16, at 7:08 a.m containing glucose resident's room. LP bedside stand and resident's bed. Afte	testing a resident's blood r was tested on 9/20/16, at d by LPN-B. LPN-B brought r into R128's room and without nned gloves. LPN-B then left ng one glove and wiped the Super Sani-Cloth for five d it on the medication cart for B then removed the glove, r, and then placed the ray on the medication cart gauze, lancets, and alcohol wed on 9/20/16, at 8:06 a.m. lucometers are shared, so we re and after each use." LPN-B ani-Cloths were used and the n down and set them down to uickand then put it back" (in ve washed my hands before glucometer."	F	441	,		

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		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-0391 E SURVEY PLETED
		245590	B. WING _			09/;	23/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	the glucometer, retu supplies. She then washed her hands. the glucometer from a Super Sani-Cloth LPN-D explained, "" with 'purple top wipt the med [medication then put it back into glucometers and ha med med cart on th R69's fungal rash c at 7:21 a.m. LPN-D power to R69's righ her gloved hand. LF and washed her ha Following the obser had not washed her "I should wash hand did for two." R87's blood glucose 9/21/16, at 7:37 a.m medication aide (TM supplies, TMA-A pla on R87's bed. Follo TMA-A returned the cart, wiped the gluco for 15 seconds, and to the tray containin explained, "We use with Bleach. I wiped seconds and then le then put it in basket confirmed the gluco	age 20 urned it to the tray containing removed her gloves and At 7:12 a.m. LPN-D removed in the tray, wiped it briefly using , and returned it to the tray. We wipe the glucometer down e' and let it air dry. I left it on n] cart for five seconds and o tray. We use shared ave two glucometers in the ne Special Care unit." eare was observed on 9/21/16, 0 donned gloves and sprinkled at armpit and rubbed it in with PN-D then removed her gloves inds for two seconds. rvation LPN-D confirmed she r hands thoroughly and stated, ds for 30 seconds and I only e testing was observed on n. performed by trained MA)-A. After gathering aced the tray and glucometer owing the blood sugar testing, e glucometer to the medication cometer with a Dispatch wipe d 10 seconds later, returned it ng the supplies. TMA-A then e the Dispatch Hospital Towels d the glucometer down for 10 et it air dry for 10 seconds and t with the supplies." TMA-A preters were shared, and she r testing six residents' blood	F 44	41			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245590 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 441 Continued From page 21 F 441 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 alucometer 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 alucometers 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

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		AND HUMAN SERVICES			FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245590	B. WING		09/;	23/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa adequately."	.ge 22	F 441			
	9/21/16, at 11:31 a. were to be thorough resident use, and the one minute on the r wipes dried very qu wipes from the cart not the same one I not seen this one b directed the user to	ved regarding glucometers on m. She stated glucometers hly wiped using wipes between ne glucometers left to dry for medication cart. RN-A said the tickly. She obtained Dispatch and stated, "This product is am used to using and I have efore." The instructions o wipe the surface with wipe t and let stand for one minute				
	(DON) stated staff or Super Sani-Wipe staff to wipe down of but did not indicate should be left to dry glucometers were s verified, "Currently don't clean them pr anything stating how be cleaned or dried the glucometers pro supplies, and update					
	on 9/22/16, at 1:06 use hand sanitizer thand washes. Hand and after any woun med passes. You s 20-30 seconds. I wastarting to work her	wed regarding hand washing p.m. She stated, "We can two to three times between d washing is important before d cares, blood sugar checks, hould wash hands for about as trained right away when re and annually."				

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		AND HUMAN SERVICES			FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY IPLETED
		245590	B. WING		09/:	23/2016
NAME OF !	PROVIDER OR SUPPLIER	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	expected staff to wa resident cares. Add to wash their hands resident's room and administration. The facility's 9/1/11 staff to disinfect all between every resid with approved clear Sani cloth. 4. Allow	age 23 ash their hands between ditionally, staff were instructed s upon entering and leaving a d during medication , Glucometer policy directs 'multiple use' glucometers dent useWipe glucometer ning productdispatch/Super the unit to completely dry (2 the wipes manufacturer	F 441	1		
	instructionsThe g separate area, mus used for the proced the cleaning proces resident." R115's cares were	observed on 9/22/16, at 7:23 sistant (NA-F). NA-F donned				
	gloves and assisted Although R115 had (a tube in the bladd urinary drainage), h for a bowel movem had unsuccessful re bedpan, covered R him the call light, re room touching the R door. When asked hands after removing that she usually we her hands, "I know a bad habit." At 7:30 a.m. register not acceptable to re	d R115 to use a bedpan. I an indwelling Foley catheter ler to provide continuous ne had requested the bedpan ent. After R115 reported he esults, NA-F removed the 115 with a blanket, handed emoved her gloves and left the handle on both sides of the why she did not wash her ing her gloves, NA-F explained ont across the hallway to wash it's not a good thing to do. It's ered nurse (RN)-A stated it was emoved gloves and then leave rst washing hands. RN-A				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	E SURVEY PLETED
		245590	B. WING			09/2	23/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 463 SS=E	place of handwashi you need to wash y R115 had a positive tract infection. The facility's 8/1/16 Hygiene policy indic single most effective of infection, will be p and thoroughly to p spread of infection wounds of any kind surface that may ha bloodUse friction vigorously for at lea 483.70(f) RESIDEN ROOMS/TOILET/B. The nurses' station resident calls throug from resident rooms facilities. This REQUIREMEN by: Based on observat review, the facility fa functioning for 1 of environmental conor the memory care un tested, which had th residents (R5, R30,	t is taught not to use gloves in ng. When gloves comes off our hands." RN-A verified e culture showing a urinary , General Guidelines For Hand cated "Hand-washing is the e way of controlling the spread performed by staff routinely rotect residents from he Before and after touching After touching any item or two been contaminated with while scrubbing hands st 20 seconds" IT CALL SYSTEM -	F 4		Call Light was immediately reinstalle R 41 Residents bathroom at time of Survey. A check was also completed call lights in all other Resident rooms bathrooms during the week of surve others were found missing. Call light system in SCR (Memory C Unit) was reset within 12 minutes of system going down. Evidence was obtained through a computer genera printout of call light activity on this United	d for s and y. No are the ated	10/23/16

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245590 **B** WING 09/23/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET LUTHERAN HOME **BELLE PLAINE, MN 56011** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 463 Continued From page 25 F 463 R41's bathroom call light was not and was provided to the Surveyor prior to present/available on 9/20/16, at 10:49 a.m. R41 Exit, as was a copy of our Policy explained, "It has been gone awhile. One night I regarding what staff are to do when the was up and was going to use it and it was not call lights do go down. The Policy there." She did not recall how long it had been requires checking on all Residents who cannot, or won't, leave their room, every missina. 15 minutes. All other residents will be moved to common areas to be monitored. Licensed practical nurse (LPN)-C was then asked to come to R41's bathroom. LPN-C verified the Staff were re-educated on our Policy of call light was not present in the resident's what to do when call lights go down bathroom, and stated she would address the through In-service training. issue with maintenance staff immediately. All room and bathroom call lights will be visibly checked on a daily bases when On 9/21/16, at 12:30 p.m. LPN-C reported R41's rooms are cleaned by housekeeping. call light had been missing since 9/15/16, nearly a They (housekeeping) will also do checks week prior. LPN-C said the maintenance man on all Call lights on a monthly basis went to R41's bathroom to repair the toilet. The consisting of actually testing each light, call light was on the back of the toilet tank. "He assuring they are being activated and moved it to the plumbing cart to fix the toilet and displayed in the hallway. forgot to put it back where he found it." She further explained that the facility had met and Results of the daily and monthly checks were working on a plan to prevent the problem will be reported to the QA Committee on a from happening again. A letter was to be provided Quarterly basis. 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.

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		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245590	B. WING	i		09/2	23/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LUTHER	AN HOME			-	511 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 463	Continued From pa	ge 26	F 4	463			
	9/19/16, at 7:11 p.r immediately reported (LPN)-F. LPN-F ch confirmed that actu on the memory card system from reside to the nurse station assistant pagers.) L what time the syste Technology] right av 9/23/16, at 12:53 p. recall if I answered after lunch. It is the assignment to walk the call lights system not sure if the hous lights that day. I assistent to the call lights on the un On 9/23/16, at 1:37 stated, "I expect st We also have a pla on the memory card problem and it is ou upgraded."	s not working when tested on m. The problem was ed licensed practical nurse hecked the call system and ally the whole call light system e unit was not working. (The nt rooms and toilet/bathrooms ; and to the nurse/ nursing _PN-F stated, "I am not sure m fell. I will call IT [Information way to get it fixed." On .m. LPN-F stated, "I do not any call lights [on 9/19/16] day shift housekeeper's around and check whether m is functioning or not. I am ekeeper had checked the call sume she might have done c." LPN-F identified eight ve been capable of using their it. 7 p.m. the administrator aff to do 15 minute checks. n to upgrade the call system e unit. It has a software utdated. Its needs to be ght System Failure policy					
	developed 9/23/16, the Lutheran Home environment for all	indicated "It is the policy of					
F 497	483.75(e)(8) NURS	E AIDE PERFORM	F 4	497			10/30/16

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM A	10/21/2016 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			B) DATE	SURVEY LETED
		245590	B. WING			09/2	3/2016
NAME OF I	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				I1 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 497 SS=E	REVIEW-12 HR/YF	INSERVICE	F 4	97			
	of every nurse aide months, and must p education based or reviews. The in-set sufficient to ensure nurse aides, but mu per year; address a determined in nurse and may address th as determined by th aides providing set	mplete a performance review at least once every 12 provide regular in-service the outcome of these rvice training must be the continuing competence of ust be no less than 12 hours reas of weakness as a aides' performance reviews be special needs of residents be facility staff; and for nurse vices to individuals with nts, also address the care of aired.					
	by: Based on interview facility failed to prove evaluations for 15 c E4, E5, E6, E7, E8, E15,) whose person and had worked in months. This had the residents in the fact Findings include: On 9/23/16, at 2:00 nursing assistants (approximately 3:15 returned with eight E3, E4, E6, E7, E9, the evaluations are	p.m. evaluations for 10 NAs) were requested. At p.m. the administrator employee evaluations (E1, E2, E10) and said "unfortunately not very current." All eight of e overdue. In addition, E5 and			All active Nursing assistant staff annuareviews which were not current, were completed. All "inactive" (LOA's; Students; Workers comps; etc.) nursinassistants will have their annual review completed prior to returning to work. Reviews will include comments about a positive things they do every day, and a point out "areas of improvement" need as appropriate for each individual. Completion of Reviews will be audited HR and Administration on a monthly basis. Results of this monitoring will be discussed with the Quality Assurance Committee, which meets Quarterly.	ng ws the also ded I by	

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		AND HUMAN SERVICES				FORM	10/21/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245590	B. WING			09/:	23/2016
NAME OF	PROVIDER OR SUPPLIER	-	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 497	administrator expla part time employee employee evaluatio and E12. E11's had E12's had not been Three more full time E13, E14, E15 were the employee's per- not had evaluations On 09/23/16, at 5:1 human resource en- that she utilized a tr and the directors ha She further stated t behind than I would Employee date of h provided by facility E1's evaluation was E2's evaluation was E3's evaluation was E5's evaluation was E6's evaluation was E6's evaluation was E7's evaluation was E10's evaluation was E11's dated was sig E12's evaluation was E11's evaluation was	ined they were temporary or s. Two additional full time ons were requested for E11 I not been completed timely. completed within the year. e employee evaluations for e requested. E14's was not in sonnel file. E13 and E15 had s completed in the past year. 6 p.m. during an interview with nployee (HR)-A, she explained racking system for evaluations ad access to the spread sheet. he evaluations were "further t like to be." ire and evaluation dates were as follows: s effective through 6/21/16 s effective through 8/5/16 s effective through 8/22/14 s effective through 5/12/16 s signed 2/26/15 s not received e was signed 3/5/15 as dated 8/22/13 gned 3/20/15 as effective through 3/15/16 as effective through 3/15/16 as effective through 3/15/16	F	197			

Facility ID: 00605

If continuation sheet Page 29 of 29

		AND HUMAN SERVICES & MEDICAID SERVICES	T5:	590024		APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01 1951 ADDITION		E SURVEY PLETED
		245590	B. WING		09/:	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ГS	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
,	Minnesota Departn Fire Marshal Divisi dated 9/22/2016, B	Survey was conducted by the nent of Public Safety - State on. At the time of this survey uilding 02 of Lutheran Home und not to be in substantial				
	in Medicare/Medica 483.70(a), Life Saf edition of National (NFPA) 101 Life Sa Existing Health Ca PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY spections Division Suite 145		EPOC		6
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electro	nically Signed					10/20/20

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

PRINTED: 10/24/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION 01 - MAIN BUILDING 01 1951 ADDITION		E SURVEY PLETED
		245590	B, WING	_		09/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				311 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	ĸ	000			
	DEFICIENCY MUS	n@state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE			÷.		
	FOLLOWING INFO 1. A description of v to correct the defici	what has been, or will be, done					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	Minnesota Departn Fire Marshal Divisio dated 9/22/2016, B	Survey was conducted by the nent of Public Safety - State on. At the time of this survey uilding 01 of Lutheran Home					
	compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National	und to be in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 19 re Occupancies.					
	buildings. The origi is one-story, has no	surveyed as three separate nal building was built in 1951, b basement, is fully fire and is of Type V(111)					
	detection in the cor	re alarm system with smoke ridors and spaces open to the monitored for automatic fire					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00605

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE		FORM A	10/24/2016 APPROVED 0938-0391 SURVEY PLETED
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	0 NG	1 - MAIN BUILDING 01 1951 ADDITION		LETED
		245590	B. WING			09/2	22/2016
	PROVIDER OR SUPPLIER			61	REET ADDRESS, CITY, STATE, ZIP CODE 1 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	department notifica rooms are protecte detection. The faci and had a census o	ige 2 tion. Additionally, all resident d with automatic smoke lity has a capacity of 97 beds of 94 at time of the survey. 42 CFR, Subpart 483.70(a) is	K	000			

Event ID: CZEB21

Facility ID: 00605

If continuation sheet Page 3 of 3

		AND HUMAN SERVICES & MEDICAID SERVICES			F5590024		APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 02 - 1961, 1970, 1998 ADDITIONS		E SURVEY IPLETED
		245590	B. WING			09/	22/2016
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			~		
	Minnesota Departm Fire Marshal Divisio dated 9/22/2016, B Belle Plaine was for	Survey was conducted by the nent of Public Safety - State on. At the time of this survey uilding 02 of Lutheran Home und not to be in substantial e requirements for participation					
	483.70(a), Life Safe edition of National F	aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 19 re Occupancies.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			EPOC		
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00605

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/24/2016 FORM APPROVED OMB NO 0938-0391

					OMB NO.	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG 02 - 1961, 1970, 1998 ADDITIONS		PLETED
		245590	B. WING		09/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
UTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 025 SS=E	least a one half hou constructed in acco barriers shall be pe atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD i Smoke barriers sh least a one half hou constructed in acco barriers shall be pe atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. On facility tour betw on 9/22/2016, base	all be constructed to provide at ar fire resistance rating and ordance with 8.3. Smoke similated to terminate at an ws shall be protected by by wired glass panels and 7.5 s not met as evidenced by: all be constructed to provide at ar fire resistance rating and ordance with 8.3. Smoke similated to terminate at an ws shall be protected by r by wired glass panels and 7.5 veen 09:00 AM and 12:00 PM ed on observation and interview vetration was found above	ΚO	25 The penetration located abo Tile near room U108 was fille resistant material on the sam discovered, was corrected by Maintenance Director (DL)	ed with a fire le day it was	
K 062 SS=D	the (12) residents v This deficient pract Facility Maintenanc discovery NFPA 101 LIFE SA Required automatic continuously mainta condition and are ir periodically. 19.7 9.7.5 This STANDARD i Required automatic continuously mainta	ice could affect the safety of vithin the smoke compartment. ice was confirmed by the se Director at the time of FETY CODE STANDARD c sprinkler systems are ained in reliable operating hspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, s not met as evidenced by: ic sprinkler systems are ained in reliable operating hspected and tested	КO	162 The 1" hole next to the show the closet on 2nd Floor was fire resistant material on the	filled with a	9/22/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CZEB21

Facility ID: 00605

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 02 - 1961, 1970, 1998 ADDITIONS	(X3) DA CO	. 0938-039 TE SURVEY MPLETED
		245590	B. WING		09	/22/2016
	PROVIDER OR SUPPLIER AN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 611 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
K 062	 9.7.5 On facility tour bet on 9/22/2016, bas revealed that a 1" in closet on 2nd flo was found This deficient practice (6) residents we This deficient practice (6) residents we 	age 3 7.6, 4.6.12, NFPA 13, NFPA 25, ween 09:00 AM and 12:00 PM ed on observation and interview hole next to fire sprinkler head bor Special Care Residence tice could affect the safety of <i>i</i> thin the smoke compartment. tice was confirmed by the ce Director at the time of	K 062	discovered, was corrected by ou maintenance Director (DL)	Ir	

PRINTED: 10/24/2016 FORM APPROVED

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CZEB21

Facility ID: 00605

If continuation sheet Page 4 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES



PRINTED: 10/24/2016 FORM APPROVED

		& MEDICAID SERVICES			(X3) DATE SURVEY
STATEMENT OF I AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /	E CONSTRUCTION 03 - 2008 KITCHEN/LAUNDRY/OFFICE	COMPLETED
		245590	B. WING		09/22/2016
NAME OF PROV	VIDER OR SUPPLIER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST MAIN STREET ELLE PLAINE, MN 56011	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉT
K 000 INI		TS .	K 000		
FI	RE SAFETY				
AL DE SIG PA US US ON CC SU	LEGATION OF C EPARTMENT'S A GNATURE AT TH GE OF THE CM SED AS VERIFIC PON RECEIPT O NSITE REVISIT ONDUCTED TO JBSTANTIAL CO	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN			
AC A L Miu Fir da	CORDANCE Wi Life Safety Code nnesota Departm re Marshal Divisio ted 9/22/2016, Bi	TH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety - State on. At the time of this survey uilding 02 of Lutheran Home und not to be in substantial			
in 48 ed (Ni	Medicare/Medica 3.70(a), Life Safe ition of National I	e requirements for participation and at 42 CFR, Subpart by from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 19 e Occupancies.		EPOC	
CC	EASE RETURN DRRECTION FO EFICIENCIES (-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			
Sta 44	ealth Care Fire In ate Fire Marshal 5 Minnesota St., Paul, MN 55101	Division Suite 145			
	ECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 10/20/2

Electronically Signed

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/24/2016 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 03 - 2008 KITCHEN/LAUNDRY/OFFICE		E SURVEY PLETED
		245590	B. WING	-		09/;	22/2016
	PROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 511 WEST MAIN STREET BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenmar	tate.mn.us and	K	000			
	THE PLAN OF CO	RRECTION FOR EACH					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	Minnesota Departm Fire Marshal Divisio Building 03 of Lutho	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, eran Home Belle Plaine was				L.	
	requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) 101 Life Sa New Health Care C This facility will be a buildings. The 4th A	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 18		2			
	protected and is of The facility has a fin detection in the cor corridors, which is	Type II(111) construction. re alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. Additionally, all resident					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00605

and the second se		& MEDICAID SERVICES				MB NO.	APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 3 - 2008 KITCHEN/LAUNDRY/OFFICE	(X3) DAT COM	E SURVEY IPLETED
		245590	B, WING			09/	22/2016
AME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UTHER	AN HOME				1 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa rooms are protecte detection.	age 2 d with automatic smoke	ĸ	000			
	The facility has a ca census of 94 at tim	apacity of 97 beds and had a e of the survey.					
	The requirement at MET.	t 42 CFR, Subpart 483.70(a) is					
	5						
RM CMS-25	67(02-99) Previous Version	s Obsolete Event ID: CZEB2	21	Faci	ility ID: 00605 If contir	uation she	eet Page 3 o

If continuation sheet Page 3 of 3

PRINTED: 10/24/2016



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

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Lutheran Home October 10, 2016 Page 2

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 meeth

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

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00605	B. WING		C 09/2) 3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	AN HOME		MAIN STRI AINE, MN 3			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 10/20/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 35

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00605	B. WING			23/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 9/19/16 through Department's staff, the following correct	9/23/16, surveyors of this visited the above provider and the above provider and the above provider and the stude.				
	correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta	rour electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	umber appears in the far left o Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

Minneso	ta Department of He	alth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00605	B. WING		09/2) 3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRI LAINE, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
		y was also conducted by the nent of Health on 9/23/16.				
		complaint H5590022 was ne of the licensing survey. The substantiated.				
2 300	MN Rule 4658.0105	5 Competency	2 300			10/30/16
	are able to demons techniques necessa needs, as identified resident assessment	ist ensure that direct care staff trate competency in skills and ary to care for residents' through the comprehensive nts and described in the n of care, and are able to ned duties.				
	by: Based on interview facility failed to prove valuations for 15 c E4, E5, E6, E7, E8, E15,) whose person and had worked in	ent is not met as evidenced and document review, the vide annual performance of 15 employees (E1, E2, E3, E9, E10, E11, E12, E13, E14, nnel records were reviewed the facility for greater than 12 ne ability to impact all 90 lity.		All active Direct Care Staff annual which were not current, were comp All "inactive" (LOA's; Students; Wo comps; etc.) Direct Care Staff will I their annual reviews completed prior returning to work. Reviews will include comments abo positive things they do every day, a point out "areas of improvement" n as appropriate for each individual.	oleted. rkers nave or to out the and also	
linnosota D	nursing assistants (approximately 3:15	p.m. evaluations for 10 NAs) were requested. At p.m. the administrator employee evaluations (E1, E2,		Completion of Reviews will be aud HR and Administration on a month Results of this monitoring will be discussed with the Quality Assuran	ly basis.	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00605	B. WING			C 23/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LUTHEF	RAN HOME		「MAIN STR _AINE, MN :			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 300	E3, E4, E6, E7, E9, the evaluations are the evaluations are the evaluations wer E8 had not had an a administrator explai part time employee employee evaluatio and E12. E11's had E12's had not been Three more full time E13, E14, E15 were the employee's pers not had evaluations On 09/23/16, at 5:1 human resource en that she utilized a tr and the directors has She further stated t behind than I would Employee date of h provided by facility we E1's evaluation was E3's evaluation was E3's evaluation was E4's evaluation was E5's evaluation was E6's evaluation was E7's evaluation was E11's dated was sig E12's evaluation was E11's evaluation was	E10) and said "unfortunately not very current." All eight of e overdue. In addition, E5 and evaluation, and the ined they were temporary or s. Two additional full time ns were requested for E11 not been completed timely. completed within the year. e employee evaluations for e requested. E14's was not in sonnel file. E13 and E15 had completed in the past year. 6 p.m. during an interview with nployee (HR)-A, she explained tacking system for evaluations ad access to the spread sheet. he evaluations were "further like to be." ire and evaluation dates were as follows: s effective through 6/21/16 s effective through 8/5/16 s effective through 8/22/14 s effective through 11/9/14 s not received s effective through 5/12/16 s signed 2/26/15 s not received e was signed 3/5/15 as dated 8/22/13 gned 3/20/15 as effective through 3/15/16 as effective through 3/15/16	2 300	Committee, which meets Qu	Jarterly.	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
		00605	B. WING		/23/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
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2 300	Continued From pa	ge 4	2 300		
	facility could ensure responsibility for ev competency and ev improvement. The reviewed by person	HOD OF CORRECTION: The e appropriate staff share aluating nursing assistant valuations reflect areas for system for tracking could be is responsible. Audits could be results brought to the quality w.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 560	MN Rule 4658.0408 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		10/30/1
	comprehensive plat objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).			
	by: Based on observati review, the facility fa the provide services decreased range of resident (R87) revie Findings include: R87 was reported to	ent is not met as evidenced on, interview and document ailed to develop a care plan for s to minimize the risk for f motion (ROM) for 1 of 1 ewed for ROM services. o have a contracture to the ty (UE) following a stroke		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	r

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	LETED
		00605	B. WING			, 3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 560	at 10:40 a.m RN-/ not utilize a splint, r affected limb. On 9/21/16, at 11:3 No splint device wa denied he utilized a exercises for the co Following the obser at 11:48 a.m. RN-A utilized a splint in th wear it during the d together." RN-A ver splint nor did he rec explaining the resic were not monitoring information related status. A Restorative Nursi 5/19/14, noted R87 and joint stiffness, a provide ROM to pre stiffness to right up R87's care plan dat resident was involv program and was a plan did not direct s or to apply a splint. An Order Commun indicated a therapis for R87, but the R8 discontinued and st monitor."	A reported R87, however, did for ROM services to the 8 a.m. R87 was in his room. Is in use. When asked, R87 a splint or was provided ontracture to his right UE. rvation and interview with R87 explained the resident had he past, but had refused to ay and then refused it "all rified R87 was not utilizing a ceive ROM services from staff, lent "does it on his own." Staff g or documenting any to R87's ROM or contracture ing Assessment note dated was at risk for contractures and staff were advised to event contractures and joint per and lower extremities. ted 4/16/15, indicated the ed with the restorative nursing assisted with walking. The care staff to provide ROM services ication Form dated 2/16/16, st recommended a hand brace 7 refused to wear it, so it was taff were to "continue to		10/17/16 Nurse Managers will monitor a with contractures at a minimum quarterly and update Care pla appropriate. Staffs were educated on the in ensuring Resident needs are a the Care plans; and that we al each Individualized Resident (meet the Resident needs DON will audit on a quarterly b residents with Contractures ha POC in place; plus discuss he our QA Committee meetings o quarterly basis.	m of n as nportance of entered on re following Care Plan to pasis, that all ave proper r findings at	
		continuation of restorative				

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00605	B. WING		09/2	23/2016
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2 560	Continued From pa	age 6	2 560			
	non-compliance. W	o non-ambulatory status and /ill re-address with PT/OT ccupational therapy] as				
	current Guideline F	Long Term Care Card or or Daily Care sheet directed exercises or ROM for R87.				
	(NA)-G reported re she "loosened it up cares, but she deni	a.m. a nursing assistant garding R87's contracture that " when providing morning ed providing structured ROM entation of completion.				
	therapist (OTR) exp made a Soft Pro ha moderate flexion co thumb). R87 began only wearing the sp started to refuse ap the beginning of 20 device was discont explained R87 had ambulation services refused the ambula program was disco were needed to fulf facility's restorative stated she would ha continue to provide	v at 7:58 a.m. the occupational plained the therapy staff had and splint (used to treat portractures of wrist, hand and n using the splint on 11/5/14, plint at night per his choice. He oplication of the splint towards 16, and consequently the inued on 2/16/16. She further received restorative ROM and s, but because the resident ation services, the entire ntinued since two services fill the requirements of the nursing program. The OTR ave expected nursing to ROM when therapy services sidents maintained their ROM with hemiplegia.				
	R87 had not been the restorative prog would have expected	a.m. RN-A stated ROM for put into the NA's tasks after gram stopped. RN-A stated, "I ed this to be done. It falls on. It wasn't done." She verified	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	03/	23/2010
		611 WES	T MAIN STRE	ET		
			PLAINE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ge 7	2 560			
	it should have beer hemiplegia.	provided for a resident with				
	(DON) stated she w resident had ROM therapy, the resider and started on a re- their current status beneficial. The DOI expected a care pla and other directions The care plan should	p.m. the director of nursing yould have expected when a limitations but had completed at would have been assessed storative program to maintain if services were deemed N also stated she would have an to include ROM, therapy s on the care of a resident. Id have been updated as a resident was getting the care				
	purpose for ROM "i through as full a ran maintain joint mobil prevent contracture	, ROM policy indicated the s to move the resident's joints nge of motion as possible, lity and muscle strength, es, increase strength and educe pain and prevent obility."				
	A care plan policy v obtained.	vas requested but not				
	facility could review who require ROM/s care plan developm	HOD OF CORRECTION: The care planning for residents plints. Persons responsible fo tent could be educated. Audits and the results brought to the	r			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			10/30/1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	
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2 895	Continued From pa	ige 8	2 895			
	that is directed town through positioning implemented and n comprehensive res of nursing services development of a n provides that: B. a resident wit receives appropriat	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the sursing care plan which the a limited range of motion the treatment and services to notion and to prevent further of motion.				
	by: Based on observati review, the facility f minimize the risk for (ROM) for 1 of 1 re ROM services. Findings include: R87 was reported t right upper extremi according to registe at 10:40 a.m RN-/ not utilize a splint, r affected limb. On 9/21/16, at 11:3 No splint device wa denied he utilized a	ent is not met as evidenced ion, interview and document ailed to provide services to or decreased range of motion esident (R87) reviewed for o have a contracture to the ty (UE) following a stroke ered nurse (RN)-A on 9/20/16, A reported R87, however, did nor ROM services to the 8 a.m. R87 was in his room. as in use. When asked, R87 a splint or was provided portracture to his right UE.		Resident R-87 Care Plan was a reflecting the contracture and p treatment was put into place fo To assure NAR has provided P RUE twice a day starting 9/23/ ⁻ Nurse Managers will assess all house Residents for possible contractures; and if any found, to Therapies, or an appropriate be developed immediately. The assessments will be completed 10/17/16 Nurse Managers will monitor al with contractures at a minimum quarterly and update Care plan appropriate. Staffs were educated on the im ensuring Resident needs are e the Care plans; and that we are each Individualized Resident C	r Nurses: ROM to 16. I other in either refer POC will ese 1 by II residents of as portance of ntered on e following	
		rvation and interview with R87 explained the resident had		meet the Resident needs		

STATE FORM

CZEB11

If continuation sheet 9 of 35

STATEMEN	a Department of He T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMPI	
			A. BUILDING		C	1
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NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
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2 895	Continued From pa	ige 9	2 895			
	wear it during the d together." RN-A ver splint nor did he rec explaining the resid were not monitoring	ne past, but had refused to ay and then refused it "all rified R87 was not utilizing a ceive ROM services from staff, lent "does it on his own." Staff g or documenting any to R87's ROM or contracture		DON will audit on a quarter residents with Contractures POC in place; plus discuss our QA Committee meeting quarterly basis.	s have proper her findings at	
	5/19/14, noted R87 and joint stiffness, a provide ROM to pre-	ing Assessment note dated was at risk for contractures and staff were advised to event contractures and joint per and lower extremities.				
	resident was involv program and was a	ted 4/16/15, indicated the ed with the restorative nursing assisted with walking. The care staff to provide ROM services				
	indicated a therapis for R87, but the R8	ication Form dated 2/16/16, st recommended a hand brace 7 refused to wear it, so it was taff were to "continue to				
	3/17/16, stated "dis programs related to non-compliance. W	ing Assessment note dated continuation of restorative o non-ambulatory status and /ill re-address with PT/OT ccupational therapy] as				
	current Guideline F	Long Term Care Card or or Daily Care sheet directed exercises or ROM for R87.				
		a.m. a nursing assistant garding R87's contracture that				
TE FORM			6899	CZEB11	If continuation	n sheet 10

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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2 895	Continued From pa	lge 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.					
	R87 had not been the restorative prog would have expecte under my jurisdiction	a.m. RN-A stated ROM for put into the NA's tasks after gram stopped. RN-A stated, "I ed this to be done. It falls on. It wasn't done." She verified a provided for a resident with	4			
	stated she would had ROM limitation the resident would started on a restora	p.m. the director of nursing ave expected when a resident s but had completed therapy, have been assessed and ative program to maintain their vices were deemed beneficial.				
nesota D	The facility's 7/1/16 epartment of Health	, ROM policy indicated the				
ATE FORI	-		6899 C	ZEB11	If continuati	on sheet 11 o

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	СОМІ	E SURVEY PLETED	
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2 895	purpose for ROM "i through as full a rar maintain joint mobil prevent contracture activity tolerance, re complications of mo SUGGESTED MET facility could evaula ROM/splints. An ed ROM technique cou who decline ROM/s increase complianc decline. Audits coul results brought the	s to move the resident's joints nge of motion as possible, ity and muscle strength, s, increase strength and educe pain and prevent	2 895		
21375	Program Subpart 1. Infection home must establiss control program des sanitary environmed This MN Requiremed by: Based on observation review, the facility fator to minimize the risk residents (R50, R12 blood glucose monion potential to affect 10 the shared glucomed failed to ensure processor	 Subp. 1 Infection Control; In control program. A nursing th and maintain an infection signed to provide a safe and nt. In the second sec	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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONS A. BUILDING:		(X3) DATE SURV COMPLETE		
		00605	B. WING		09/23	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STATE, 2	ZIP CODE		
UTHER	AN HOME		T MAIN STREET LAINE, MN 56011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG C	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ge 12	21375			
	utilized an indwellin	g catheter.		rding to Manufactures		
	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.		in pro Indiv for th appro Nurs staff audit DON resul Com	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.		
	procedure for clean at 7:32 a.m. LPN-A Sani-Cloths to clean R45, and stated, "I glucometer before a used for multiple pa two seconds and I s do not know how lo glucometers" (after sugar). R128's blood sugar 8:02 a.m. performe	wed regarding the facility's ing glucometers on 9/20/16, reported she had used Super in the glucometers for R50 and just sort of wiped over the and after. Glucometers are titients. I washed my hands for should have for 15 seconds. I ng I am supposed to wipe the testing a resident's blood was tested on 9/20/16, at d by LPN-B. LPN-B brought into R128's room and without				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C
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21375	Continued From pa	ge 13	21375			
	seconds and place five seconds. LPN- used hand sanitize glucometer in the tr	Super Sani-Cloth for five d it on the medication cart for B then removed the glove, r, and then placed the ray on the medication cart gauze, lancets, and alcohol				
	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 dryand they dry quickand then put it back" (in the tray). "I should've washed my hands before and after using the glucometer."					
	a.m. regarding the glucometers, "I wou about the glucomet	interview on 9/20/16, at 8:27 facility's process for cleaning uld have to ask the night nurse er cleaning protocol. We have all our residents. I don't know protocol is."				
	9/21/16, at 7:08 a.n containing glucose resident's room. LP bedside stand and resident's bed. Afte LPN-D removed he the glucometer, ret supplies. She then washed her hands. the glucometer fror a Super Sani-Cloth LPN-D explained, "	blood sugar testing for R45 on n. LPN-D obtained the tray testing supplies into the PN-D set the tray on R45's the glucometer on the r testing R45's blood sugar, er gloves, and without cleaning urned it to the tray containing removed her gloves and At 7:12 a.m. LPN-D removed n the tray, wiped it briefly using , and returned it to the tray. We wipe the glucometer down e' and let it air dry. I left it on				
	the med [medicatio	n] cart for five seconds and o tray. We use shared				

Minneso	ota Department of He	alth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00605	B. WING		C 09/23/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LUTHER	AN HOME		F MAIN STRE LAINE, MN 5			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	lge 14	21375	· · · · · · · · · · · · · · · · · · ·		
	glucometers and ha	ave two glucometers in the ne Special Care unit."				
	at 7:21 a.m. LPN-D power to R69's righ her gloved hand. Ll and washed her ha Following the obset had not washed he	are was observed on 9/21/16, donned gloves and sprinkled at armpit and rubbed it in with PN-D then removed her gloves nds for two seconds. rvation LPN-D confirmed she r hands thoroughly and stated, ds for 30 seconds and I only				
	9/21/16, at 7:37 a.m medication aide (TI supplies, TMA-A pla on R87's bed. Follo TMA-A returned the cart, wiped the gluo for 15 seconds, and to the tray containin explained, "We use with Bleach. I wiped seconds and then I then put it in baske confirmed the gluod	e testing was observed on n. performed by trained MA)-A. After gathering aced the tray and glucometer wing the blood sugar testing, e glucometer to the medication cometer with a Dispatch wipe d 10 seconds later, returned it ng the supplies. TMA-A then the Dispatch Hospital Towels d the glucometer down for 10 et it air dry for 10 seconds and t with the supplies." TMA-A pmeters were shared, and she r testing six residents' blood				
	at 9:09 a.m. perform tray containing sup placed the testing s breakfast tray. Afte sugar, she returned wiped it with a Supe 15 second, and retu allowing the glucom	ting was observed on 9/21/16, med by LPN-E. LPN-E set the plies on R158's recliner and strips on the resident's r testing the resident's blood d the glucometer to the cart, er Sani-Cloth for approximately urned it to the tray without neter to dry. Following the explained, "We use Super				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00605			(X3) DATE SURVEY COMPLETED C 09/23/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		03/	23/2010
			T MAIN STREI			
LUTHER	AN HOME		LAINE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 15	21375			
	Sani-ClothsTake 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.					
	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 wer 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."					
	9/21/16, at 11:31 a. were to be thorough resident use, and th one minute on the r wipes dried very qu wipes from the cart	ed regarding glucometers on m. She stated glucometers hly wiped using wipes between he glucometers left to dry for nedication cart. RN-A said the ickly. She obtained Dispatch and stated, "This product is am used to using and I have				

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LUTHER	AN HOME		T MAIN STRE LAINE, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
21375	Continued From pa	age 16	21375				
		wipe the surface with wipe t and let stand for one minute					
	(DON) stated staff or Super Sani-Wipe staff to wipe down of but did not indicate should be left to dry glucometers were s verified, "Currently don't clean them pr anything stating how be cleaned or dried	8 a.m. the director of nursing was to utilize either Dispatch es. The facility's policy directed glucometers in between uses, how long the glucometer y. The DON verified the stored with opened gauze and we put it in the basket and we roperly because we don't have w long the glucometers should I. I will go to the units, clean operly, and will separate the te the policy."					
	on 9/22/16, at 1:06 use hand sanitizer hand washes. Hand and after any woun med passes. You s	wed regarding hand washing p.m. She stated, "We can two to three times between d washing is important before d cares, blood sugar checks, hould wash hands for about as trained right away when re and annually."					
	expected staff to ware resident cares. Add	n 9/23/16, at 10:23 a.m. she ash their hands between ditionally, staff were instructed s upon entering and leaving a d during medication					
	staff to disinfect all between every residuith approved clear Sani cloth. 4. Allow	, Glucometer policy directs 'multiple use' glucometers dent useWipe glucometer ning productdispatch/Super the unit to completely dry (2 the wipes manufacturer					

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED	
		00605	B. WING			C 09/23/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
LUTHER	AN HOME		「MAIN STRE _AINE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	instructionsThe g separate area, mus used for the proced the cleaning proces resident." R115's cares were a.m. by nursing ass gloves and assisted Although R115 had (a tube in the bladd urinary drainage), h for a bowel movem had unsuccessful re bedpan, covered R him the call light, re room touching the I door. When asked hands after removin that she usually we her hands, "I know a bad habit." At 7:30 a.m. register not acceptable to re the room without fir further explained, "I place of handwashi you need to wash y	ge 17 lucometer must be kept in it not be in with clean supplies lure. The nurse must complete is before moving to another observed on 9/22/16, at 7:23 sistant (NA-F). NA-F donned d R115 to use a bedpan. an indwelling Foley catheter er to provide continuous ie had requested the bedpan ent. After R115 reported he esults, NA-F removed the 115 with a blanket, handed moved her gloves and left the handle on both sides of the why she did not wash her ng her gloves, NA-F explained nt across the hallway to wash it's not a good thing to do. It's ered nurse (RN)-A stated it was emoved gloves and then leave st washing hands. RN-A It is taught not to use gloves in ng. When gloves comes off our hands." RN-A verified e culture showing a urinary	21375	DEFICIENC	Y)		
	Hygiene policy indic single most effectiv of infection, will be and thoroughly to p spread of infection. wounds of any kind	, General Guidelines For Hand cated "Hand-washing is the e way of controlling the spread performed by staff routinely rotect residents from he Before and after touching After touching any item or ave been contaminated with					

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IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	03/	23/2010
	AN HOME	611 WES	T MAIN STRE	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21375		ge 18 while scrubbing hands	21375			
	facility could re-edu handwashing, and employee handwas potential for the spr be conducted and t quality committee.	THOD OF CORRECTION: The acate employees on proper conduct audits to ensure shing practices minimize the read of infection. Audits could he results brought to the R CORRECTION: Twenty-one				
21426	Prevention And Con (a) A nursing home maintain a compret infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tition (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.	21426			10/30/1
	epartment of Health					

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	PROVIDER OR SUPPLIER	611 WES	DRESS, CITY, T MAIN STR LAINE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	age 19	21426			
	by: Based on record re ensure symptom so testing for 1 of 5 re- immunization recor the facility failed to E2) were properly s working with reside Findings include: R155 was admitted Immunization recor had not screened th symptoms of tuberor resident received tu required. Registered nurse (If 12:03 p.m. that whe admitted to the faci for TB testing. If no responsible for con testing. During an interview director of nursing of standing order for T staff had not compl DON stated, "We m resident did not get until 9/22/16." E1's immunization symptom screening 9/23/16, at 3:25 p.m E1 reported she had	ent is not met as evidenced eview the facility failed to creening and tuberculin skin sidents (R155) whose ds were reviewed. In addition ensure 2 of 5 employees (E1, screened for TB prior to ents as required. It to the facility on 8/30/16. rds revealed the facility staff he resident for potential culosis (TB) nor had the uberculin skin testing (TST) as RN)-B explained on 9/23/16, at en a resident was newly lity, they had physician orders t, the nurse manager was tacting the physician regarding on 9/23/16, at 10:20 a.m. the confirmed R155 did not have a TST. Additionally, the facility leted symptom screening. The nissed this one and the t the first step TB screening records lacked evidence of TB g or step one and two TST. On n. the administrator explained id provided the facility with a another facility, but the facility		The Resident (R155) who did documentation of a Tubercul was completed on 10/8/16; <i>A</i> residents were also audited to completion of the TB Test. N managers will monitor all new to verify that the test are com DON will audit all new admiss quarter to confirm compliance to the QA committee quarter Employee # E1 was removed floor immediately and directed chest x-ray, which was incom workup was drawn and resul negative; Employee was resi work status; Employee # E2 completed by:10/30/16 HR will audit all new employed TB tests are completed accor Policy and State Regulations bring Audit findings to QA Cor quarterly base.	in skin test; All other to confirm urse w admissions apleted. sions each te and report ly. d from the ed to obtain a aclusive; blood ts were tored to active will be ees to ensure ording to our a. HR will then	

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NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRE LAINE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 20	21426			
	could not provide th	ne records.				
	symptom screening and the first step TS the records lacked had been administer administrator stated	records showed that although y was completed on 6/1/16, ST was completed on 6/3/16, evidence the second step TST ered and read as required. The d on 9/23/16, at 4:20 p.m. E2 e second step administered the interview.				
	facility could review ensuring timely and immunizations to re conduct education employees to ensur	HOD OF CORRECTION: The /develop their system for appropriate TB esidents and employees, and with the appropriate re implementation. Audits and the results brought to the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990			10/30/16
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify th caregiver, the natur maltreatment, any e maltreatment, the n reporter, the time, c	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
			B. WING		С	
		00605			09/23/2016	
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
UTHER	AN HOME		T MAIN STR LAINE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
21990	Continued From pa	ge 21	21990			
	the suspected maltir reporter may disclosion in section 13.02, and section 144.335, to comply with this suff This MN Requirement by: Based on interview facility failed to imment abuse to the design 6 of 7 residents (R1 R157) who were rew This also potentially residing in the facilities Findings include: The facility's Vulner revealed the followith 1. R66 had a left for of the incident was event was reported of Health (MDH) by (LSW)-A on 7/18/16 (7/18/16) indicated, [director of nursing] within 24 hours."	ent is not met as evidenced and document review, the rediately report allegations of lated State agency (SA) for by 7, R39, R61, R66, R129, viewed for abuse prohibition. affected all 90 residents ty. able Adult Reporting Tool ng: emoral neck fracture; the time 4:00 p.m. on 7/17/16. The to the Minnesota Department licensed social worker 5. The investigative report "Social Worker, DON , and administrator notified sical injury that was not ed with the date and time of wn." The incident report was The event was reported to		The Vulnerable Adult reporting Policy w updated to reflect the Minnesota langu of reporting "Immediately" to SA (CEP) and Administrator; eliminating the language of "no later than 24 hours" as stated in the Federal Language. A Cop the new Policy was given to the Survey team on 9/22/16. Nurse Managers and other key staff we educated immediately on the States interpretations/expectations, with the n Policy taking effect 9/22/16. Remaining Staff were educated throug In-services/training regarding the importance of reporting any potential o suspicious events as described in the policy "immediately" to their supervisor the SA (CEP) and Administrator. Traini was also provided to staff on what are Reportable events as described by Sta 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 Reporta	age y of ere ew h r or ng te	
	MDH by registered investigative report	nurse (RN)-C on 8/10/16. The (8/10/16) indicated, "DON, updated immediately."		reported to the SA (CEP) and present those audit findings to our QA Committ on a quarterly basis.	ee	
	3. R17 had physic	al injury that could not be				

If continuation sheet 22 of 35

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
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		00605	B. WING		09/	09/23/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
UTHER	AN HOME		T MAIN STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From pa	age 22	21990				
	and time on the rep reported to MDH by (LPN)-G on 3/25/16 the administrator w 4. R61 had an ev 8/27/16. The date a was 8/27/16, at 12: document to the Mi was made to the th 8/27/16 to report th reported to MDH by through the online a investigative report	ed dated 3/24/16 with the date bort "unknown." The event was y licensed practical nurse 5. The record did not indicate ras immediately notified. ent reported to MDH on and time on the incident report 58 a.m. The initial report DH, indicated a telephone call the Common Entry Point on the event. The event was later y activity aide-A on 8/30/16, reporting system. The (8/30/16) indicated "Families, the, administrator, and MD of incident."					
	side dated 4/4/16. incident report was was reported to ME	brasion/rug burn to the right The date and time on the "4/4/16 at 8:15 p.m. The even DH by the LSW-A on 4/5/16. indicate the administrator was d of the event.					
	reasonably explained incident report was was no evidence w when it had been re- included in the info An Oracle email was	tical injury that could not be ed. The date and time on the 10/24/16, at 5:10 a.m. There ho had reported the event or eported, as the pages were no rmation provided by the facility as dated 10/27/15, at 2:35 p.m indicate the administrator was d of the event.					
	when an event was the charge nurse, c	27 a.m. LSW-B stated that discovered, it was reported to director of nursing, or is something that we feel like					

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LUTHER	AN HOME		T MAIN STRE				
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21990	Continued From pa	lge 23	21990				
	incident report and hours during the we incident reports to o meeting [IDT] and we that point, the team Vulnerable Adult iss Department of Hea facility staff often di the facility policy ind hours, and they rep Later that day at 12 interview regarding the event by teleph then completed onl reiterated they were were to report "no l	ight away, we will fill out an submit to MDH within the 24 eekendWe will bring the pur interdisciplinary team we will discuss it further. At a will decide to report sues within the 24 hours to the lth." LSW-B explained the d not report "immediately" as dicated they had up to 24 borted within that timeframe. 2:22 p.m. LSW-B stated in an R17 that a nurse had reported one on 8/27/16, and "It was ine on 8/30/16." LSW-B e following the policy that they onger than 24 hours from the ge that the incident occurred "					
	10:30 a.m. events r [facility] staff immed the MDH can be up DON further explain be informed of all en night. The charge r the situation was "r DON or administrat filled out by the nur MDH if it was deter situation. The DON R61's events and v were immediately r reporting system as there had been cor	an interview on 9/22/16, at needed "to be reported to diately, but the actual report to to 24 hours in time." The ned the charge nurse was to events, including during the nurse then determined whether eportable" and "may" call the tor. The event reports were se and reporting made to mined to be a reportable reviewed R157, R129 and erified none of the situations eported using the online is required. She explained that of usion regarding the required orting and whether the facility port.					
		n 9/22/16, at 12:38 p.m.					
nesota De ATE FORM	epartment of Health		6899 C	ZEB11		on sheet 24 d	

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
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LUTHER	AN HOME		T MAIN STRE			
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21990	Continued From pa	ge 24	21990			
		d their policy and procedure y had up to 24 hours to report				
	9/22/16, at 2:01 p.n weekend, "we woul Monday morning to with an injury, they was warranted to c	nurse (LPN)-C stated on n. if an event happened on the d report on it first thing the IDT team." If it was a fall informed LSW-A. "If we felt it ontinue with the process and luring the weekend."				
	9/23/16, at 8:31 a.n any events such as outside intervention may be reportable if facts of the situation decision about report was reportable, the supervisor "should said they could con a day. He explained	tated in an interview on h. he was to be informed of falls, someone who needed a or suspicious events that mmediately. He evaluated the h and them they made a bring to MDH at that time. If it registered nurse (RN) report it." The administrator tact him at anytime, 24 hours d they would immediately uspected or involved in a				
	Tool reviewed on 9/ the above potential	ed Vulnerable Adult Reporting (23/16 indicated "*** If any of reportable incidents occur be notified immediately, but urs ***."				
	policy indicated, "In soon as possible, b from the time initial occurred has been and the Director of unknown injuries w	6, Vulnerable Adult Report mediately is defined as: as ut no longer than 24 hours knowledge that the incident receivedThe Administrator Nursing will be notified on any ithin 24 hours of incidents must also be				

	ta Department of He					
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRE LAINE, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21990	of Health with 24 ho as required at 42 C	ge 25 o the Minnesota Department ours of the incidents discovery FR 483.13 (C) (2) [Centers for caid Services regulatory	21990			
	Policies could be up reporting to the SA Appropriate staff wh potentially reportab immediately report administrator could direction to the pers the administrator to Following the report nursing, and license proceed with the im- could be provided. and the results brou	THOD OF CORRECTION: bdated to reflect immediate and administrator as required. no immediately learned of le incidents could also to the SA as required. The complete this or provide this son immediately reporting to ensure this was completed. t, the administrator, director of ed social worker could vestigation. Re-education Audits could be conducted ught to the quality committee.				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. Th assessment of the environment, and it factors which may e and a statement of to minimize the risk	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				10/30/16

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE DATE	
22000	Continued From pa	age 26	22000			
	agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other individue vulnerable adults; (other vulnerable adults; (other vulnerable; (plan must detail the minimize the risk there as on ably be expected adults; (of a vulnerable adults; (other vulnerable; (other vul	including a home health care val care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other (2) the person's risk of abusing dults; and (3) statements of the to be taken to minimize the tt person and other vulnerable poses of this paragraph, the des self-abuse. except home health agencies attendant services providers, nerable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to nat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows of riminal sical aggression if it receives om a law enforcement n a medical record prepared by other health care provider, or g assessments of the				
	by:	ent is not met as evidenced				
	Based on interview	and document review, the		Individual Residents ever	nts tound not in	

Innesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00605		LE CONSTRUCTION	(X3) DATE SL COMPLE C 09/23/	TED
				05/23/	2010
AME OF PROVIDER OR SUPPLIER					
UTHERAN HOME		「 MAIN STR _AINE, MN			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
22000 Continued From pa	ge 27	22000			
facility failed to dev prohibition policies reporting of allegati designated State av (R17, R39, R61, R6 potentially affecting facility. Findings include: The facility's undate Tool reviewed on 9/ the above potential Administrator must no later than 24 how The facility's 3/30/1 policy indicated, "In soon as possible, b from the time initial occurred has been and the Director of unknown injuries w onsetReportable electronically sent t of Health with 24 ho as required at 42 C Medicare and Medi reference]." The facility's Vulner revealed the follow 1. R66 had a left of the incident was event was reported of Health (MDH) by (LSW)-A on 7/18/10	elop and operationalize abuse that included immediately ons to the administrator and gency (SA) for 6 of 7 residents 56, R129, R157), and all 90 residents residing in the ed Vulnerable Adult Reporting (23/16 indicated "*** If any of reportable incidents occur be notified immediately, but urs ***." 6, Vulnerable Adult Report mediately is defined as: as but no longer than 24 hours knowledge that the incident receivedThe Administrator Nursing will be notified on any ithin 24 hours of incidents must also be o the Minnesota Department burs of the incidents discovery FR 483.13 (C) (2) [Centers for caid Services regulatory		Compliance were reviewed by the Management team. The Vulnerable Adult reporting Po- updated to reflect the Minnesota Is of reporting "Immediately" to SA (d and Administrator; eliminating the language of "no later than 24 hour stated in the Federal Language. A the new Policy was given to the St team on 9/22/16. Nurse Managers and other key sta educated immediately on the State interpretations/expectations, with Policy taking effect 9/22/16. Remaining Staff were educated the In-services/training regarding the importance of reporting any poten suspicious events as described in policy "immediately" to their super the SA (CEP) and Administrator. T was also provided to staff on what Reportable events as described b and Federal Regulations; our inter investigation process, and the follor requirement of submitting report to (CEP) within 5 days. Social Service will audit future Ref events as to the timeliness of bein reported to the SA (CEP) and press those audit findings to our QA Cor on a quarterly basis.	blicy was anguage CEP) rs" as Copy of urvey aff were es the new trough tial or the visor or Training t are y State rnal ow up o SA portable	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
	00605		B. WING			23/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
UTHER	AN HOME		T MAIN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	 within 24 hours." 2. R39 had a phys reasonably explained the incident "unknown completed 8/9/16.1 MDH by registered investigative report administrator were 3. R17 had physic reasonably explained and time on the rep reported to MDH by (LPN)-G on 3/25/16 the administrator were 4. R61 had an eve 8/27/16. The date at was 8/27/16, at 12:: document to the MI was made to the the 8/27/16 to report the reported to MDH by through the online rep investigative report DON, Charge Nurss [physician] notified 5. R129 had an all side dated 4/4/16.1 incident report was 	sical injury that was not ed with the date and time of wn." The incident report was The event was reported to nurse (RN)-C on 8/10/16. The (8/10/16) indicated, "DON, updated immediately." cal injury that could not be ed dated 3/24/16 with the date ort "unknown." The event was dicensed practical nurse 5. The record did not indicate as immediately notified. ent reported to MDH on und time on the incident report 58 a.m. The initial report DH, indicated a telephone call e Common Entry Point on e event. The event was later d activity aide-A on 8/30/16, reporting system. The (8/30/16) indicated "Families, e, administrator, and MD		DEFICIENC		
	 immediately notified 6. R157 had phys reasonably explained incident report was 	indicate the administrator was d of the event. ical injury that could not be ed. The date and time on the 10/24/16, at 5:10 a.m. There ho had reported the event or				

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
0060		00605	B. WING	B. WING		C 23/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
		611 WES	T MAIN STRE	ET		
LUTHER	AN HOME	BELLE P	LAINE, MN 5	6011		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIENC	(Y)	
22000	Continued From pa	ige 29	22000			
	when it had been re	eported, as the pages were not				
		rmation provided by the facility.				
		as dated 10/27/15, at 2:35 p.m.				
		indicate the administrator was				
	immediately notified	d 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 weekendWe 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					
		sues within the 24 hours to the				
		Ith." LSW-B explained the				
		d not report "immediately" as				
		dicated they had up to 24				
		orted within that timeframe.				
		2:22 p.m. LSW-B stated in an				
	interview regarding	R17 that a nurse had reported	I			
		one on 8/27/16, and "It was				
	•	ine on 8/30/16." LSW-B				
		e following the policy that they				
		onger than 24 hours from the				
	has been received.	ge that the incident occurred				
	The DOM stated in	on intonvious on 0/00/10 at				
		an interview on 9/22/16, at needed "to be reported to				
		diately, but the actual report to				
		to 24 hours in time." The				
		ned the charge nurse was to				
		vents, including during the				
		urse then determined whether				
		eportable" and "may" call the				
	DON or administrat	tor. The event reports were				
		se and reporting made to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00605	B. WING		C 09/23/2	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRE PLAINE, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	MDH if it was deter situation. The DON R61's events and v were immediately r reporting system as there had been cor time frame for repo- had 24 hours to rep LSW-A explained of facility staff follower which indicated the to the MDH. Licensed practical n 9/22/16, at 2:01 p.m weekend, "we woul Monday morning to with an injury, they was warranted to c report it we would of The administrator s 9/23/16, at 8:31 a.m any events such as outside intervention may be reportable facts of the situatio decision about repor was reportable, the supervisor "should said they could con a day. He explained	mined to be a reportable reviewed R157, R129 and erified none of the situations eported using the online s required. She explained that ifusion regarding the required rting and whether the facility		DEFICIENC	·Υ)	
	Policies could be up reporting to the SA	THOD OF CORRECTION: pdated to reflect immediate and administrator as required. ho immediately learned of				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:			COM	PLETED
00605		00605	B. WING		C 09/23/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	RAN HOME		T MAIN STRE			
			LAINE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From pa	ge 31	22000			
	immediately report administrator could direction to the pers the administrator to Following the repor nursing, and license proceed with the inv could be provided. A and the results brou	le incidents could also to the SA as required. The complete this or provide this son immediately reporting to ensure this was completed. t, the administrator, director of ed social worker could vestigation. Re-education Audits could be conducted ught to the quality committee. R CORRECTION: Twenty-one				
23010	MN Rule 4658.463 Construction	5 A Nurse Call System; New	23010			10/23/16
	communication sys from the resident ar required by this par system, if electrical connected to the er Nurse calls and em of being inactivated central annunciator	must be equipped with a tem designed to receive calls nd nursing service areas t. The communication ly powered, must be nergency power supply. ergency calls must be capable only at the points of origin. A must be provided where the om the nurses' station.				
	resident's bed. Cal communication dew they are within reac from a resident mus station, activate a li- bedroom, and activ medication room, n room, soiled utility r multi-corridor nursir	must be provided for each l cords, buttons, or other ices must be placed where h of each resident. A call st register at the nurses' ght outside the resident ate a duty signal in the ourishment area, clean utility oom, and sterilizing room. In ng units, visible signal lights t corridor intersections.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL C	
	00605		B. WING			8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		611 WEST	MAIN STR	EET		
LUTHER	AN HOME	BELLE PI	AINE, MN	56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
23010	Continued From pa	ige 32	23010			
	by: Based on observati review, the facility f functioning for 1 of environmental conc the memory care u tested, which had th residents (R5, R30,	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.		Call Light was immediately reinsta 41 Residents bathroom at time of A check was also completed for ca in all other Resident rooms and ba during the week of survey. No othe found missing. Call light system in SCR (Memory Unit) was reset within 12 minutes system going down. Evidence was obtained through a computer gene	Survey. all lights athrooms ers were Care of the	
	R41's bathroom ca present/available o explained, "It has b was up and was go	II light was not n 9/20/16, at 10:49 a.m. R41 een gone awhile. One night I ing to use it and it was not recall how long it had been		printout of call light activity on this and was provided to the Surveyor Exit, as was a copy of our Policy re what staff are to do when the call I go down. The Policy requires che all Residents who cannot, or won't their room, every 15 minutes. All o residents will be moved to commo	Unit, prior to egarding ights do cking on t, leave ther	
	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			to be monitored. Staff were re-edu on our Policy of what to do when o go down through In-service trainin All room and bathroom call lights w visibly checked on a daily bases w rooms are cleaned by housekeepi	all lights g. will be rhen ng. They	
				(housekeeping) will also do checks Call lights on a monthly basis cons actually testing each light, assuring are being activated and displayed hallway.	sisting of g they	
	forgot to put it back further explained th were working on a from happening ag with staffs' payched	where he found it." She hat the facility had met and plan to prevent the problem ain. A letter was to be provided cks on 9/23/16 asking staff to ence and operation of the call		Results of the daily and monthly cl will be reported to the QA Commit Quarterly basis.		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
	00605		B. WING			C 23/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	AN HOME		T MAIN STRE LAINE, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLETI DATE
23010	Continued From pa	ge 33	23010			
	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.					
			t			
	stated, "I expect st	7 p.m. the administrator aff to do 15 minute checks. n to upgrade the call system				

OF CORRECTION	IDENTIFICATION NUMBER:				E SURVEY PLETED
00605				09/23/2016	
PROVIDER OR SUPPLIER					
AN HOME					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	ige 34	23010			
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 residentsAll resident/staff will be immediately informed of call light system outage."					
system for checking developed and app could be conducted	g call light function could be ropriate staff trained. Audits and the results brought to the	•			
TIME PERIOD FOF (14) days.	R CORRECTION: Fourteen				
	AN HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa on the memory car problem and it is ou upgraded." The facility's Call Li developed 9/23/16, the Lutheran Home environment for all will be immediately outage." SUGGESTED MET system for checking developed and app could be conducted quality committee for	PROVIDER OR SUPPLIER STREET AI AN HOME 611 WES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES Centinued From page 34 On the memory care unit. It has a software problem and it is outdated. Its needs to be upgraded." Deficiency of the Lutheran Home To provide a safe Environment for all residentsAll 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	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AN HOME 611 WEST MAIN STRE BELLE PLAINE, MN 50 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 34 23010 on the memory care unit. It has a software problem and it is outdated. Its needs to be upgraded." 23010 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 residentsAll 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	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AN HOME 611 WEST MAIN STREET BELLE PLAINE, MN 56011 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC Continued From page 34 23010 on the memory care unit. It has a software problem and it is outdated. Its needs to be upgraded." 23010 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 residentsAll 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	00605 B. WING