DEPARTMENT OF HEALTH					CENTERS FOR MEI			
					AND TRANSMITTAL TE SURVEY AGENCY		D: G8HL acility ID: 00605	
1. MEDICARE/MEDICAID PROVIDE		3. NAME AND AI			IE SURVEI AGENCI	4. TYPE OF ACTION		
(L1) 245590		(L3) LUTHERAN				1. Initial	2. Recertification	
2.STATE VENDOR OR MEDICAID NO (L2) 751243100	Э.	(L4) 611 WEST MAIN STREET (L5) BELLE PLAINE, MN			(L6) 56011	3. Termination 5. Validation 7. On-Site Visit	 4. CHOW 6. Complaint 9. Other 	
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After		
6. DATE OF SURVEY 10/26/. 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDIN 09/30	G DATE: (L35)	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	nts:	
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Serv		
12. Total Facility Beds	97 (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 T. Medical Dire 8. Patient Room 9. Beds/Room 		
13.Total Certified Beds	97 (L17)	B. Not in Con Requirem	npliance with Prog ents and/or Applic	ram ed Waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF 97	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
George Schroeder, SFMO		1	2/09/2013	(L19)	Anne Kleppe, Enforcement Specialist 06/17/2014 (L20)			
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBILIT _X_ 1. Facility is Eligible to Pa 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	I CIVIL		ncial Solvency (HCFA-2572 bl Interest Disclosure Stmt (l b :		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	. (I		
OF PARTICIPATION 01/01/1992	BEGINNINC	G DATE	ENDING DAT	ſΈ	VOLUNTARY 00 01-Merger, Closure		<u>TARY</u> leet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	001411101	leet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	a	
(L27)	-	n of Admissions:	(L44)		04-01101 Reason for whithawar	07-Provider 00-Active	Status Change	
	D. Reschiu St	spension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	. ,		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)	12/04/2013		(L33)	DETERMINATION APPI	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 245590

On 10/26/13, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Public Safety. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the standard survey, effective 10/10/13. Refer to the CMS 2567B for both health and life safety code.

Effective 10/10/13, the facility is certified for 97 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5590

June 17, 2014

Ms. Mariann Wiebusch, Administrator Lutheran Home 611 West Main Street Belle Plaine, Minnesota 56011

Dear Ms. Wiebusch:

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 10, 2013, 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. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Ane Klegge

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

cc: Licensing and Certification File

Lutheran Home June 17, 2014 Page 2



Protecting, Maintaining and Improving the Health of Minnesotans

December 9, 2013

Ms. Mariann Wiebusch, Administrator Lutheran Home 611 West Main Street Belle Plaine, Minnesota 56011

RE: Project Number F5590021

Dear Ms. Wiebusch:

On September 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Public Safety for a standard survey, completed on September 20, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 26, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 10, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 10, 2013 and therefore remedies outlined in our letter to you dated September 27, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Are Kleggse

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

Enclosure cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245590	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01 1951 ADDITION	(Y3) Date of Revisit 10/26/2013
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).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 10/10/2013	ID Prefix		Correction Completed	ID Prefix		Correction Completed
-	NFPA 101		Reg. #			Reg. #		
LSC	K0050		LSC			LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
		-						
Reg. #			Reg. #			Reg. #		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		-						
Reg. #			Reg. #			Reg. #		
		Correction			Correction			Correction
		Completed	ID Drofin		Completed	ID Drofin		Completed
		-						
Reg. # LSC			Reg. # LSC			Reg. # LSC		
		Correction			Correction			Correction
		Completed	ID Profix		Completed	ID Profix		Completed
		-				D //		
Reg. # LSC			Reg. # LSC			Reg. # LSC		
Reviewed B		Ву	Date:	Signature of Sur	veyor:		Date:	
State Agen	cy PS/AK		12/09/2013			25822	10/2	26/2013
	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date:	
CMS RO								
Followup t	o Survey Completed or	1:	<u> </u>	Check for any Uncor			he Feelling	
	9/17/2013			Uncorrected Defic	iencies (CM	3-2307) Sent to t	ne Facility? YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245590	(Y2) Multiple Construction A. Building B. Wing 02 - 1961, 1970, 1998	ADDITIONS (Y3) Date of Revisit 10/26/2013
Name of Facility	Street Addres	s, City, State, Zip Code
LUTHERAN HOME		T MAIN STREET _AINE, 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).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 10/10/2013	ID Prefix		Correction Completed 10/10/2013	ID Prefix		Correction Completed
-	NFPA 101		-	NFPA 101		Reg. #		
LSC	K0029		LSC	K0050		LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		-	Reg. #			Dec. #		
LSC			LSC			LSC		
		Correction Completed			Correction Completed			Correction Completed
ID Prefix		-	ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
			130					
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #								
LSC			LSC			LSC		
Reg. #			Deg #			D //		
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Da	te:
State Agen	cy PS/AK		12/09/2013			258	322 10	0/26/2013
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Da	te:
Followup t	o Survey Completed or 9/17/2013	1:		Check for any Uncon Uncorrected Defic			the Feelling	ES NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245590	(Y2) Multiple Construction A. Building B. Wing 03 - 2008 KITCHEN/LAUNDRY/OFFICE	(Y3) Date of Revisit 10/26/2013
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).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y	5) I	Date
ID Prefix		Correction Completed 10/10/2013	ID Prefix		Correction Completed 10/10/2013	ID Prefix			Correction Completed
-	NFPA 101		-	NFPA 101		Reg. #			_
LSC	K0050		LSC	K0067		LSC			_
		Correction Completed			Correction Completed	ID Desfus			Correction Completed
ID Prefix						_			_
Reg. #			Reg. #			Reg. #			-
			200						_
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. # LSC			Reg. # LSC			Reg. # LSC			_
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #			Reg. #			D "			
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:		C	Date:	
State Agen	cy PS/AK		12/09/2013	3		25	822	10/26	/2013
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		C	Date:	
Followup t	o Survey Completed on 9/17/2013	:		Check for any Uncor Uncorrected Defic	rected Defic	iencies. Was a S-2567) Sent to t	L . E	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 1. I. Statement of Financial Solvency (HCFA-2572) 2. 1. Facility is Fligible (L21) 2. Undership Control Interest Disclosure Stmt (HCFA-1513) 2. Facility is not Eligible (L21) 2. TERMINATION ACTION: (L30) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 01/01/1992 01/01/1992 00 INVOLUNTARY 00 INVOLUNTARY 01/24) (L41) (L25) 27. ALTERNATIVE SANCTIONS 06-Fail to Meet Health/Safery 02-Dissatisfaction W/R cimbursement 06-Fail to Meet Agreement 03. (L27) (L44) B. Rescind Suspension Date: (L44) 09-Active 09-Active 18. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 30. REMARKS 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 12/04/2013 31.						ND TRANSMITTAL 'E SURVEY AGENCY	ID: G8HL Facility ID: 00605
6. DECEGENERY 09/20/2013 (1.4) 05.NNND 46 FRUE 10 N HONE FECULY 54 ENDING DATE: (1.3) 8. ACCEPTION NUMBER 1000000000000000000000000000000000000	(L1) 245590 (L3) LUTHERAN HOM 2.STATE VENDOR OR MEDICAID NO. (L4) 611 WEST MAIN S (L2) 751243100 (L5) BELLE PLAINE, S 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIEF					<u>02</u> (L7)	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
Pom (1): A. B. Compliance With	 6. DATE OF SURVEY 09/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 		02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	
Tammy Alberts, HFE NE II 1023/2013 1023/2013 1023/2013 1023/2013 1023/2013 1020/2013	From (a): A. In Compliance With To (b): Program Requirements 12. Total Facility Beds 97 (L18) 97 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: 13. Total Certified Beds 97 (L17) 14. LTC CERTIFIED BED BREAKDOWN X B. Not in Compliance with Program Requirements and/or Applied Waivers: 18 SNF 18/19 SNF 19 SNF ICF 10. Total SurVey AGENCY REMARKS (JF APPLICABLE SHOW LTC CANCELLATION DATE):						 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21. 1. Sutement of Financial Solvency (HCFA-2572) 2 0 onership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 2 Facility is not Eligible (1.21) 21. 0. RIGGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 0 F PARTICIPATION BEGINNING DATE ENDING DATE 01/00/1992 01/00/1992 05-Fail to Meet Health/Safety 01/01/1992 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 01/HER (L27) Rescind Suspension Date: (L44) 02. INTERMEDIARY/CARRIER NO. 03. REMARKS 03-Risk of Involuntary Termination 01/HER 01/01/192 (L45) 30. REMARKS						Late Opalon Enf	orcement Specialist 12/04/2013 (L20)
OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY 00 INVOLUNTARY 01/01/1992 (L41) (L25) 03-Fail to Meet Health/Safety 03-Fail to Meet Health/Safety (L24) (L41) (L25) 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) 03-Risk of Involuntary Termination OTHER 07-Provider Status Change 00-Active (L27) B. Rescind Suspension Date: (L45) 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS O33001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 12/04/2013 12/04/2013	_X1. Facility is Eligible to Parti	cipate	20. COM	PLIANCE WITH CI		 Statement of Financ Ownership/Control 	ial Solvency (HCFA-2572)
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 03-Risk of Involuntary Termination OTHER A. Suspension of Admissions: (L44) 04-Other Reason for Withdrawal 07-Provider Status Change (L27) B. Reseind Suspension Date: (L45) 00-Active 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 12/04/2013 12/04/2013	OF PARTICIPATION 01/01/1992	BEGINNING		ENDING DATE		VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 12/04/2013		A. Suspension of	of Admissions:	(L44)		-	07-Provider Status Change
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 12/04/2013	28. TERMINATION DATE:	29				30. REMARKS	
	31. RO RECEIPT OF CMS-1539			OF APPROVAL DAT		DETERMINATION APPRO	VAL

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G8HL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00605
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

CCN# 245590

At the time of the standard survey completed September 20, 2013, the facility was not in substantial compliance and the most serious deficiencies were 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5407

September 27, 2013

Ms. Mariann Wiebusch, Administrator Lutheran Home 611 West Main Street Belle Plaine, Minnesota 56011

RE: Project Number S5590024

Dear Ms. Wiebusch:

On September 20, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970 Telephone: (651) 201-3794 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 30, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 30, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

Lutheran Home September 27, 2013 Page 4

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 20, 2013 (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

Lutheran Home September 27, 2013 Page 5

Services that your provider agreement be terminated by March 20, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <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.

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Lutheran Home September 27, 2013 Page 6 Feel free to contact me if you have questions.

Sincerely,

Sincerely,

Colleen Feach

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring PO Box 64900 Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

		AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245590	B. WING			09/2	20/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME				11 WEST MAIN STREET ELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	FO	000			
	September 16 thou Home was found to	rvey was conducted gh 20, 2013 and Lutheran b be in compliance with 42 bart B, requirements for Long s.					
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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

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PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l • _ /		E CONSTRUCTION 01 - MAIN BUILDING 01 1951 ADDITION	(X3) DATE SURVEY COMPLETED		
		245590	B. WING			09/	17/2013	
	PROVIDER OR SUPPLIER			6'	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST MAIN STREET ELLE PLAINE, MN 56011	13		
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Dc:	ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.						
09.20.2013	Minnesota Departm Fire Marshal Divisio Building 01 of Luthe found not to be in su requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ty from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 19 e Occupancies.			DEC.			
EKIT:		R THE FIRE SAFETY			OCT 1 4 2013			
50	prian 1	ER/SUPPLIER REPRESENTATIVE'S SIGN			administrator	10/1		
ny deficienc her safegua	y statement ending with a rds provide sufficient prot	in asterisk (*) denotes a deficiency white ection to the patients. (See instructions	ch the inst s.) Except	titutio t for i	on may be excused from correcting providing nursing homes, the findings stated above are	t is deten disclosat	nified that le 90 days	

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 THE FOR MEDICARE & MEDICAID SERVICES ----

STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01 1951 ADDITION	(X3) DATE SURVEY COMPLETED	
		245590	B. WING		09/	17/2013
	PROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa St Paul, MN 55101- By email to: Barbara.Lundberg@ Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFC 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre This facility will be s buildings. The origin is one-story, has no sprinkler protected construction. The facility has a fir detection in the corr	ige 1 -5145, or Ostate.mn.us and tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency.	K 000	DEFICIENCY)	3	
	department notifica rooms are protected detection. The faci and had a census of	tion. Additionally, all resident d with automatic smoke lity has a capacity of 97 beds of 91 at time of the survey.				
K 050 SS=D	NOT MET as evide NFPA 101 LIFE SA	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD at unexpected times under	K 050			
		Observation Event (D) G8HI 21	Eor	ility ID: 00605	ation shee	et Page 2 of 4

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

Facility ID: 00605

If continuation sheet Pag

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	INB NO.	0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01 1951 ADDITION	(X3) DATE SURVEY COMPLETED	
		245590	B. WING	-		09/17/2013	
NAME OF	PROVIDER OR SUPPLIER		107	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LUTHER	AN HOME			-	11 WEST MAIN STREET BELLE PLAINE, MN 56011	14	
(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 050	The staff is familiar that drills are part o Responsibility for p assigned only to co qualified to exercise conducted between announcement may alarms. 19.7.1.2	at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible	K	050	Fire drills will be conducted a various times utilizing the ent hour shift for the 3 shifts per quarter. Fire drills will be trac and monitored for compliance the Facility Services Director. Where drills are conducted between 9 pm and 6 am, a coo announcement may be used instead of audible alarms. The responsible person for thi	ire 8 cked by led	
	Based on documer interview, the facility were conducted on staff under varying required by 2000 N	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 91			portion of the corrective plan: James Schmitt, Facility Servic Director.		10/10/13
	on 09/17/2013, the documentation for t 2012 to September the following shifts sufficiently vary the conducted: Evening: 1831, 164	veen 10:00 AM and 2:00 PM review of the fire drill he past 12 months (October 2013) revealed the drills for were completed but did not times that the drills were 0, 1833 and 1658 hours 0003 and 0100 hours					
	This deficient practi	ice was confirmed by the ance (JS) at the time of					-

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

Facility ID: 00605

If continuation sheet Page 3 of 4

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

PRINTED:	09/27/2013
FORMA	APPROVED
OMB NO	0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRU DING 01 - MAIN E	JCTION BUILDING 01 1951 ADDITION	(X3) DATI COM	E SURVEY PLETED
		245590	B. WING			09/	17/2013
	PROVIDER OR SUPPLIER AN HOME			611 WEST M	RESS, CITY, STATE, ZIP CODE IAIN STREET AINE, MN 56011		
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							ж. ж
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		HAND HUMAN SERVICES		75590021	FORM	09/27/2013 APPROVED 0938-039	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	IPLE CONSTRUCTION NG 02 - 1961, 1970, 1998 ADDITIONS	(X3) DATE SURVEY COMPLETED		
		245590	B. WING_		09/17/2013		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LUTHER	AN HOME			611 WEST MAIN STREET BELLE PLAINE, MN 56011			
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	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145 -5145, or					
ABORATORY		DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	INIA	(X6) DATE	
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ther safegua	rds provide sufficient pro date of survey whether o the date these docume	otection to the patients. (See instruction r not a plan of correction is provided. F	s.) Except or nursing h	ution may be excused from correcting providin for nursing homes, the findings stated above a nomes, the above findings and plans of correct s are cited, an approved plan of correction is re	re disclosation are disc	losable 14	

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

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STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRU		(X3) DATE SURVEY COMPLETED	
		245590	B. WING			09/	17/2013
	PROVIDER OR SUPPLIER	L		611 WEST M	RESS, CITY, STATE, ZIP CODE AIN STREET NINE, MN 56011		
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	By email to: Barbara.Lundberg@ Marian.Whitney@s						
į		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of 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 nce of the deficiency.					
	buildings. The 1st A one-story, has no b protected and is of 2nd Addition was bu no basement, is full is of Type II(111) co was built in 1998, is	surveyed as three separate addition was built in 1961, is asement, is fully fire sprinkler Type II(111) construction. The uilt in 1970, is two-stories, has y fire sprinkler protected and nstruction. The 3rd Addition s one-story, has no basement, protected and is of Type					
	detection in the corr corridors, which is r department notifica rooms are protected detection. The facil	e alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. Additionally, all resident d with automatic smoke lity has a capacity of 97 beds of 91 at time of the survey.					-
	NOT MET as evide	and the second se		Equilibre 00605	If continu	ation shee	et Page 2 of 5
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: G8HL2		Facility ID: 00605	n continu	2101 3100	

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION 02 - 1961, 1970, 1998 ADDITIONS	(X3) DATE SURVEY COMPLETED		
		245590	B. WING	;		09/	09/17/2013	
	PROVIDER OR SUPPLIER AN HOME			6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved auton option is used, the other spaces by sm doors. Doors are s field-applied protect	FETY CODE STANDARD construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are .1	K	029	 Automatic door closers were installed on the following doors Storage room 122 Soiled utility room across from U200 Storage room across from U214 Responsible person: James Schmitt, Facility Services Director. 	SS	10/10/13	
	Based on observat facility failed to main partitions and doors following requirement	s not met as evidenced by: ion and staff interview, the ntain smoke-resisting in accordance with the nts of 2000 NFPA 101, he deficient practice could esidents.			All penetrations noted on 3 ou 4 walls in hydraulic elevator r were sealed with fire- proof ca putty. Responsible person: Ja Schmitt, Facility Services Director.	oom aulk	10/10/13	
	On facility tour betw on 09/17/2013, obs following was found	een 10:00 AM and 2:00 PM ervation revealed that the :						
a	closer 2. Soiled utility room closer 3. Storage room (ov U214 - no door clos	r equipment room, has open			ŝ			

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

Facility ID: 00605

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

PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` '		E CONSTRUCTION 02 - 1961, 1970, 1998 ADDITIONS	(X3) DATE SURVEY COMPLETED	
		245590	B. WING	09/	17/2013		
	PROVIDER OR SUPPLIER			61	REET ADDRESS, CITY, STATE, ZIP CODE 1 WEST MAIN STREET ELLE PLAINE, MN 56011		
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K 029 K 050 SS=D	Continued From part These deficient prant Director of Mainten discovery. NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for pl assigned only to co- qualified to exercise conducted between announcement may alarms. 19.7.1.2 This STANDARD is Based on documer interview, the facility were conducted on staff under varying f required by 2000 N This deficient practi- residents. Findings include: On facility tour betwo on 09/17/2013, the documentation for t	ge 3 ctices were confirmed by the ance (JS) at the time of FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. anning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ce could affect all 91	K 0			t ire 8 bý led	10/10/13
ř.	documentation for t 2012 to September the following shifts						

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

Facility ID: 00605

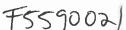
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		245590	B. WING	1.			09/17/2013	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COI 611 WEST MAIN STREET BELLE PLAINE, MN 56011	DE		
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	*TEAM COMPOSIT Gary Schroeder, Lif							
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 09/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 03 - 2008 KITCHEN/LAUNDRY/OFFICE	(X3) DATE SURVEY COMPLETED	
		245590	B. WING	-		09/	17/2013
	PROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST MAIN STREET BELLE PLAINE, MN 56011		
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	ONSITE REVISIT O CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					(40)
	Minnesota Departm Fire Marshal Divisio Building 03 of Luthe found not to be in s requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 18					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
	Health Care Fire Ins State Fire Marshal I 445 Minnesota St., St Paul, MN 55101-	Division Suite 145					
Via	1 SaDIA	ER/SUPPLIER REPRESENTATIVE'S SIGN	a	1	nunstrator 1	0/10	(X6) DATE
her safegua	Irds provide sufficient pro date of survey whether or the date these documen	tection to the patients. (See instruction pot a plan of correction is provided.	s.) Except	nt for hor	on may be excused from correcting providing nursing homes, the findings stated above an nes, the above findings and plans of correction are cited, an approved plan of correction is re-	on are dis	closable 14

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

SMDERNO P CORRECTIONS (V) DENTIFICATION NUMBER: A BUILING 03 - 2008 KITCHENLAUNDRYIOFFICE COMPLETED NAME OF PROVIDER OR SUPPLIER 245590 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE LUTHERAN HOME STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE OWNT WEST KAINS TREET D BUMMARY STATEMENT OF DEFICIENCIES D PROVIDER SCH.ADD CONRECTION OWNT BECOMPORT CACH DEFICIENCY MUST REPRECEDED BY FULL PROVIDER SCH.ADD CONRECTION D PROVIDER SCH.ADD CONRECTION OWNT BECOMPORT CACH DEFICIENCY MUST REPRECEDED BY FULL PROVIDER SCH.ADD CONRECTION D PROVIDER SCH.ADD CONRECTION OWNT BECOMPORT CACH DEFICIENCY MUST REPRECEDED BY FULL PROVIDER SCH.ADD CONRECTION D D OWNT BECOMPORT OWNT BECOMPORT OWNT BECOMPORT DEFICIENCY D D OWNT BECOMPORT D D OWNT BECOMPORT D	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		_	0	WR NO.	0938-0391	
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BELLE PLAINE, MN 56011 BELLE PLAINE, MN 56011 OPANDES PHEFX TAG Summary statement of deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY PLL REGULATORY OR LSC IDENTIFYING INFORMATION) D D PREFX TAG PROVIDERS ALL OCRRECTIVE AT ODERCIDIO (CROSS-REFERENCE) TO THE APPROPRIATE 000 Deficiency (CROSS-REFERENCE) TO THE APPROPRIATE K 000 Continued From page 1 K 000 By email to: Barbara Lundberg@state.mn.us and Marian.Whitney@state.mn.us K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: I. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as three separate buildings. The 4th Addition was built in 2006, is one-story, has no basement, is fully fire spinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection. The facility has a capacity of 97 beds and had a census of 91 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	NAME OF I	PROVIDER OR SUPPLIER		- i	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
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SS=D	K 050 SS=D	NOT MET as evider	nced by:	КC)50				

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STATEMENT	RS FOR MEDICARE	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2008 KITCHEN/LAUNDRY/OFFICE			(X3) DATE SURVEY COMPLETED	
		245590	B. WING			09/17/2013	
NAME OF I	PROVIDER OR SUPPLIER	PI CONTRACTOR OF CONTRACTOR OFONTO OF		-	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST MAIN STREET		
LUTHER	AN HOME			-	BELLE PLAINE, MN 56011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 050	Continued From par Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between announcement may alarms. 18.7.1.2 This STANDARD is Based on document interview, the facility were conducted on staff under varying required by 2000 NI This deficient praction residents. Findings include: On facility tour betwo on 09/17/2013, the documentation for t 2012 to September the following shifts of		κo	50	DEFICIENCY) Fire drills will be conducted at various times utilizing the entin hour shift for the 3 shifts per quarter. Fire drills will be track and monitored for compliance to the Facility Services Director. Where drills are conducted between 9 pm and 6 am, a code announcement may be used instead of audible alarms. The responsible person for this portion of the corrective plan: James Schmitt, Facility Service Director.	re 8 ked by ed	10/10/13
	Night: 0230, 0259, (0, 1833 and 1658 hours 0003 and 0100 hours					
		ce was confirmed by the ance (JS) at the time of					

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

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			0	MB NO	. 0938-03	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 03 - 2008 KITCHEN/LAUNDRY/OFFICE	(X3) DATE SURVEY COMPLETED		
		245590	B. WING				09/17/2013	
	PROVIDER OR SUPPLIEF	3		6	TREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST MAIN STREET BELLE PLAINE, MN 56011			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		AG PROVIDER'S PLAN OF CORRECTION SHOUL EFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETI DATE	
K 067 SS=F	Heating, ventilatin with the provisions in accordance with specifications. 9 90A This STANDARD Based on docume interview, that the air conditioning sy maintained in acco 18.5.2.1 and NFP/ noncompliant HVA residents. Findings include: On facility tour bet on 09/17/2013, do damper testing log that the fire/smoke tested. These deficient pra Facility Maintenand discovery.	AFETY CODE STANDARD g, and air conditioning comply s of section 9.2 and are installed in the manufacturer's 9.2, 18.5.2.1, 18.5.2.2, NFPA is not met as evidenced by: entation review and staff facility's general ventilating and stem (HVAC) was not ordance with the LSC, Section A 90A, Section 3-4.7. A C system could affect 91 ween 10:00 AM and 2:00 PM cumentation review of the fire for the past 4 years revealed, adampers have not been actices were confirmed by the ce Director (JS) at the time of	κo	967	The facility contracted with Protective Systems. Protectiv systems performed and completesting on all fire/smoke damp per LSC, Section 18.5.2.1 and NFPA 90A, Section 3-4.7 on 10/11/13. The testing revealed that all dampers passed the tes The testing of the dampers wa added to our preventative maintenance program/calendar Responsible Person: James Schmitt, Facility Services Director.	eted pers d t. s	10/10/3	
÷	*TEAM COMPOSI Gary Schroeder, L	ife Safety Code Spc.						
		e			a -			

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Event ID: G8HL21 Facility ID: 00605

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