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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HL4S11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**
2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 04/05/2016 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)

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

12.Total Facility Beds **109** (L18)
13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC
× B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NEII 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist 4/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1967** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
04/28/2016 (L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2016 (L33)

DETERMINATION APPROVAL

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

CCN: 24 5067

A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted and deficiencies were found. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that wsa not immediate jeopardy (Level D). The facility has been given an opportunity to correct before remedies would be imposed.

Refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0328

April 13, 2016

Mr. Joseph Gubbels, Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, Minnesota 55021

RE: Project Number S5067027

Dear Mr. Gubbels:

On April 5, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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:

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: Gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 May 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 5, 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 October 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted. The following deficiencies were issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED APR 27 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Saint Lucas MDS Focus Survey POC F 278 **Immediate Corrective Action:** The MDS for resident R8 was modified once the error was discovered. **Corrective action as it applies to others:** A review of the most recent MDS for all residents with indwelling catheters will be conducted to ensure residents with catheters have a diagnosis for their use.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joe Dubbels — TITLE: Administrator — (X6) DATE: 4/25/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 1 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents (R8) reviewed for use of an indwelling catheter. Findings include: R8's quarterly MDS dated 1/1/16, reflected R8 had an indwelling catheter however did not identify R8's diagnoses for it. A Physician's Order dated 3/10/16, directed staff to change Foley (indwelling) catheter every month on the third. The order included, "for: [diagnosis] neurogenic bladder [a bladder dysfunction caused by a neurological condition]." On 4/4/16, at 3:05 p.m. registered nurse (RN)-A, the MDS coordinator, verified the MDS had been coded to indicate R8 had an indwelling catheter. RN-A stated she had completed the MDS and was not going to indicated neurogenic bladder as the diagnoses because resident had refused the catheter to be removed several times and the facility was in the process of removing it in the next few weeks. RN-A further stated even though the physician order indicated R8 had the catheter	F 278	MDS coding re-education will be completed for MDS Nurse by May 15th, 2016. **Date of correction:** May 15th, 2016 **Recurrence will be prevented by:** MDS's will be audited to ensure accuracy of coding. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **Correction will be monitored by:** DON and/or designee	

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F 278	Continued From page 2 for neurogenic bladder it was correct as resident had requested the catheter to be put in and did not have a diagnosis through the medical record. On 4/5/16, at 11:45 p.m. the director of nursing services (DON) stated "I have never worked in a place where a resident was allowed to have a catheter because they wanted to. We are in process of removing it. DON acknowledged resident MDS assessment should have been coded with the diagnoses to justify the reason for the indwelling catheter. On 4/5/16, at 1:25 a.m. RN-D stated the indwelling catheter had been initiated 8/5/15, then the facility had attempted to remove it 9/14/15, but resident had refused and then on 9/21/15, the catheter was removed and the same day was put back in the resident. According to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 dated last revised on October 2015, the intent of the items in the bladder section was to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. "Each resident who was incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible." In addition the facility was follow the Steps for Assessment which included: "1. Examine the resident to note the presence of any urinary or bowel appliances.	F 278		

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F 278	Continued From page 3 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances."	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care related to the use of Seroquel (an antipsychotic) medication for 1 of 4 residents (R10) reviewed for antipsychotic medications. Findings include:	F 279	**F 279** **Immediate corrective action:** A care plan addressing the use of Seroquel was developed for resident R10 as soon as the concern was discovered. **Corrective action as it applies to others:** Other residents who receive antipsychotic medication will be reviewed to ensure they have individualized care plans developed to address the use of the medication.	

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F 279	Continued From page 4 On 4/5/16, at 9:25 a.m. R10 was observed seated in a wheelchair in his room watching television. When approached and asked about how he had slept, R10 stated "good." When asked about the use of Seroquel, R3 stated it helped him to sleep and that it had recently been changed to being administered at a later time which was helping him sleep through the night. R3 stated he felt more well rested in the morning now than before, because he used to wake up around three in the morning. R10's Physician Order dated 3/18/16, revealed R10 received scheduled Seroquel 50 milligrams (mg) by mouth at bedtime for chronic alcoholic brain syndrome. R10's admission Minimum Data Set dated 3/25/16, indicated R10 had received an antipsychotic for seven days since admission and had no mood or behaviors problems and/or symptoms. R10's Psychotropic Medications Care Area Assessment (CAA) dated 3/31/16, indicated resident received Seroquel daily at bedtime for insomnia per resident and directed staff to administer medication as ordered, monitor for effectiveness and or side effects of medication, to observe for changes, and to update R10's medical doctor as indicated. The CAA did not address non-pharmacological interventions. According to the care plan initiated 3/20/16, R10's diagnoses included major recurrent depressive disorder and alcoholic cirrhosis. R10's care plan did not identify the use of Seroquel, lacked a focus for major depression and alcoholic brain	F 279	The policy and procedure "Care Planning" was reviewed and remains current. Nurse Managers will be re-educated on the policy by 5/15/2016. **Date of correction:** May 15th, 2016	

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F 279	Continued From page 5 syndrome, and lacked non-pharmacological interventions. In addition, the care plan lacked direction for monitoring and evaluation of R10's behaviors and potential side effects of the medications. R10's Medication Administration Record (MAR) for 3/18 through 4/4/16, revealed R10 had received Seroquel 50 mg at bedtime daily however no care plan had been developed. On 4/5/16, at 10:51 registered nurse (RN)-B, the MDS coordinator, verified R10's care plan did not address the behaviors warranting the use of the Seroquel, and there were no non-pharmacological interventions identified on the care plan. RN-B further stated she would have expected RN-C, the unit's nurse manager, to have initiated these things on R10's care plan as R10 had been receiving the Seroquel even prior to admission. On 4/5/16 at 11:05 a.m., the director of nursing (DON) stated she expected the nurse manager for the unit to develop the care plan for residents on the short stay unit. The facility's policy and procedure for CARE PLANNING dated August 2014, included: "POLICY: ... 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death... The Resident-Centered Care Plan Format: 2. Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan. The care plan is broken down into	F 279	**Recurrence will be prevented by:** Random weekly care plan review audits will be conducted on each unit to ensure residents who receive antipsychotic medications have care plans developed which addresses the use of the medication. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **Correction will be monitored by:** DON and/or designee	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 separate focus areas: Psych-Social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Function, Hygiene ADL's [activities of daily living]/Skin, Safety/Vulnerability, Mobility/Fall ... 5. Interventions act as the means to meet the individual's needs (not to continue outmoded institutional practices). The 'recipe' for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention)."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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	245067	A. BUILDING _____ B. WING _____	04/05/2016

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ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care (POC) to accurately reflect the urinary tract infection (UTI) needs for 1 of 1 resident (R1) reviewed. Findings include: R1's care plan lacked interventions for an UTI. R1's care plan, with problem date of 3/11/15, indicated, "I need assistance of two assist with my toileting." The goals included: "I want to be clean and odor free. I want to participate in my toileting. I want to be continent of both bowel and bladder." The care plan had not been revised to include a potential for UTI, and lacked interventions for prevention of UTI in order to meet R1's needs. The Physician Orders dated 12/27/15, indicated R1 had an order for Cipro (an antibiotic-ABX) 250 mg twice a day for UTI times five days, which was initiated on 12/28/15. The UTI Risk Assessment dated 1/12/16, indicated, "Resident is continent of B&B [Bowel and Bladder]. Staff to observe for S/S [signs and symptoms)] of UTI. Update MD [medical doctor] as needed." The Bladder Assessment dated 1/12/16, included, "Resident is continent of urine. Uses urinal. Uses call light to ask for assist when needed. Assist as needed."	F 280	F 280 **Immediate corrective action:** The plan of care for resident R1 was revised to include potential for UTI. **Corrective action as it applies to others:** Residents who are found to be at risk for the development of UTI, based on most recent Bladder assessment, will have their care plans reviewed to ensure individualized care plans address the resident's potential for UTI.	

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F 280	Continued From page 8 R1's quarterly Minimum Data Set (MDS) dated 1/14/16, indicated R1 had experienced an UTI in the last 30 days. During an interview with registered nurse (RN)-A on 4/4/16, at 1:38 p.m. RN-A stated, the MDS was coded because R1 had used the ABX for UTI, positive lab results and had blood in the urine. At 3:40 p.m. RN-A verified the care plan lacked interventions for the UTI and stated, "I cannot find it. The care plan should have addressed the UTI." The facility's policy and procedure for CARE PLANNING dated August 2014, included: "POLICY: ... 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death... The Resident-Centered Care Plan Format: 2. Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan. The care plan is broken down into separate focus areas: Psych-Social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Function, Hygiene ADL's [activities of daily living]/Skin, Safety/Vulnerability, Mobility/Fall ... 5. Interventions act as the means to meet the individual's needs (not to continue outmoded institutional practices). The 'recipe' for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the	F 280	The policy and procedure "Care Planning" was reviewed and remains current. Nurse managers will be re-educated on the care planning policy by 5/15/2016. **Date of Completion: May 15th, 2016** **Recurrence will be prevented by:** Random weekly care plan review audits will be conducted on each unit to ensure residents who are at risk for the development of UTI's have individualized care plans to address the resident's potential for UTI's.	

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F 280	Continued From page 9 interventions (they are not THE intervention)."	F 280	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **Correction will be monitored by:** DON and/or designee	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 356		

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F 356	Continued From page 10 review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift, and failed to post the correct census. This had the potential to affect visitors and all 75 residents residing in the facility. Findings include: Upon entrance to the facility on 4/4/16, at 8:00 a.m. the Daily Posting of Hours was observed posted on a wall to the right of the entrance door on a clip board. The Daily Posting of Hours was dated to reflect information for 4/2/16, and indicated a census of 76. At 8:32 a.m. on 4/4/16, the facility's scheduler verified the currently posted Daily Posting of Hours was for 4/2/16. When asked who was responsible for making sure the staff posting was correctly posted, the scheduler stated when she was in the building she made sure it was posted. When asked who made sure it was posted when she was not in, the scheduler stated, "I don't know that's a good question. I just stated this job recently." At 9:10 a.m. on 4/4/16, the director of nursing (DON) was interviewed and stated the current census was only 75. At 9:20 a.m. on 4/4/16, the facility's scheduler stated, "the night charge nurse is responsible for switching the posting to make sure it is for the right date. She is new and probably needs to be oriented on this." On 4/4/16, at 9:45 a.m. the administrator stated the weekend managers are supposed to make sure the Daily Posting of Hours are posted after	F 356	F 356 **Immediate corrective action:** The daily posting of staffing hours was immediately corrected to reflect current census and staffing information. **Corrective action as it applies to others:** The policy and procedure "POSTING OF DAILY NURSING HOURS" was reviewed and remains current.	

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F 356	Continued From page 11 they have adjusted the staffing. He further stated the scheduler was supposed to switch it as soon as she got to work on weekdays. On 4/5/16, at 2:55 p.m. the cooperate consultant registered nurse and the DON acknowledged the actual hours worked by the staff were supposed to be reflected in the Daily Posting of Hours, and that the posting was supposed to be updated at the beginning of the shift to reflect the actual staff hours providing direct care. The facility's policy, Night, Day and Evening Shift Staffing Protocol, directed "It is the responsibility of the Facility House Charge to adjust the daily schedule to reflect this pattern of staffing when call-ins occur and as census fluctuates..."	F 356	Licensed nursing supervisory staff and the staffing coordinator will be reeducated on the policy by May 8th, 2016. **Date of Completion:** May 8th, 2016 **Recurrence will be prevented by:** Daily review audits will be conducted 5x per week to ensure the posted hours reflect accurate information according to facility policy. **Correction will be monitored by:** Administrator	