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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ILW9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00227

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245272**

2.STATE VENDOR OR MEDICAID NO.
(L2) **180482000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARTIN LUTHER CARE CENTER**
(L4) **1401 EAST 100TH STREET**
(L5) **BLOOMINGTON, MN** (L6) **55425**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **137** (L18)

13.Total Certified Beds **137** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	137			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Patricia Kohls Date : 04/02/2012 (L19)
[redacted] HFE NI II

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/10/2012 (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
02/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/11/12 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/23/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5272

At the time of the standard survey completed February 3, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

On March 22, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 3, 2012, effective March 9, 2012. Therefore, the remedies outlined in our letter dated February 17, 2012, will not be imposed. See attached CMS-2567B form for the results of the March 22, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5272 April 10, 2012

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minnesota 55425

Dear Ms. Barney:

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 March 9, 2012 the above facility is certified for:

137 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 137 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minneosta 55425

RE: Project Number S5272021

Dear Ms. Barney:

On February 17, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 3, 2012. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 22, 2012, the Minnesota Department of Health 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 February 3, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 9, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 3, 2012, effective March 9, 2012 and therefore remedies outlined in our letter to you dated February 17, 2012, 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,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5272r112.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245272	A. Building B. Wing	3/22/2012

Name of Facility	Street Address, City, State, Zip Code
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/09/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/09/2012**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **03/09/2012**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/09/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/.sd	04/02/12	06980	03/22/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/3/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minnesota 55425

Re: Enclosed Reinspection Results - Project Number S5272021

Dear Ms. Barney:

On March 22, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 3, 2012 with orders received by you on February 17, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5272r112lic.rtf

AH Form Approved
3/27/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00227	A. Building B. Wing	3/22/2012

Name of Facility	Street Address, City, State, Zip Code
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20545 Reg. # MN Rule 4658.0400 Subp. : LSC	Correction Completed 03/09/2012	ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. : LSC	Correction Completed 03/09/2012	ID Prefix 21990 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 03/09/2012
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/sd	04/02/12	06980	03/22/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/3/2012			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ILW9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00227

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245272**

2.STATE VENDOR OR MEDICAID NO.
(L2) **180482000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARTIN LUTHER CARE CENTER**
(L4) **1401 EAST 100TH STREET**
(L5) **BLOOMINGTON, MN** (L6) **55425**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2007**

6. DATE OF SURVEY **02/03/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **137** (L18)

13.Total Certified Beds **137** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	137			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Linda Miller, HFE NE II 03/05/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/23/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5272

At the time of the standard survey completed February 3, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5011

February 17, 2012

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minnesota 55425

RE: Project Number S5272021

Dear Ms. Barney:

On February 3, 2012, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Gayle Lantto
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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 March 14, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.
If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 3, 2012 (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 August 3, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

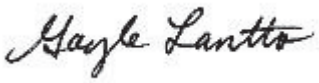
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5272s12.rtf

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	POC accepted SPanto 3/5/12	

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

Campus Administrator 03/01/2012

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

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the designated State agency and thoroughly investigate alleged abuse for 3 of 5 grievance reports reviewed, and to immediately notify administrator of alleged abuse for 1 of 5 grievance reports reviewed. Findings include: The facility produced only three incidents of alleged abuse, neglect, misappropriation of funds and/or injuries of unknown origin that were investigated for the previous year. Grievance reports were reviewed and were not investigated. A grievance report for R19 dated 8/15/11, revealed R19's family member reported: "Unexplainable bruise on (L) [left] breast, (L) [left] upper lower arm and above the waist (L) [left] side. Family not notified." The section for grievance resolution was left blank.	F 225	This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents' findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs R199 discharged on 01/26/12. R345 discharged on 11/04/11. The facility did report to State agency on 08/23/11 & 10/18/11 regarding R19 and State Agency determined that no further action was necessary. R19 was discharged on 01/01/2012. The Administrator and DON will audit all Quality Input Forms (grievance) reports to ensure investigation, notification and reporting to State Agency is completed per our revised policy. The facility will continue to investigate all potential maltreatment reports per our revised policy. The Vulnerable Adult -- Abuse Prohibition Plan was reviewed and revised on 02/29/12.	03/09/12

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F 225	Continued From page 2 A progress note, dated 8/15/11 revealed the following: "[Family member] called this writer to the resident's room to assess the bruises she discovered on the resident's left side. Per [family member] she discovered the bruises while she was helping the resident try on a new outfit she brought for (R19). Writer noted 26 cm (centimeter) by 6.5 cm bruise by the left breast area, a 16 cm by 13 cm bruise on the inner upper left arm and a 13 cm by 9 cm bruise on the left side above the waist area. All bruises appeared purplish in color...[family member] upset that the family had not been notified of any incident that lead to these bruises. Resident denied falling and could not recall if she ever pumped [sic] on anything..Response: Will continue to monitor and investigate what led to these bruises." R19's physician's progress note dated 8/23/11 revealed the following impression and plan: "Bruising left chest wall and left arm/no history of fall; doubt rib fracture; no need for x-ray at this time; etiology uncertain but to be investigated." The administrator was interviewed at 9:05 a.m. on 2/3/12. She stated a former staff member investigated the incident and believed the bruises were due to a recent change in transferring methods. The facility decided after the investigation not to report the incident to the SA. Although the investigative documenting investigation was requested, but was not provided to the surveyor for review. A grievance report filed by R199, dated 1/7/12, revealed: "Patient c/o [complained of] an incident that happened last NOC [night]. Called for help to	F 225	Staff will be re-educated about the Vulnerable Adult – Abuse Prohibition Plan including investigation, notifying the administrator, and reporting to State Agency by 03/07/12. On 02/01/12, the facility implemented, Truthpoint Satisfaction Surveys, which asks questions pertaining to potential maltreatment. This is completed quarterly for long term care residents and upon admission and discharge for our short term residents. Random staff interviews will be performed by the Administrator or designee for three months to assure that staff understand the Vulnerable Adult – Abuse Prohibition Plan. All Quality Input Forms and investigation of potential maltreatment reports will be reviewed by the Administrator and DON to ensure compliance. The Administrator is responsible for compliance. A summary of the Quality Input Forms and investigation of potential maltreatment reports will be presented to the Quality Assurance Committee each month and the recommendations from the Committee will be followed.	

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F 225	Continued From page 3 go to the bathroom and a male NAR [nursing assistant] came in to help without saying anything. He got [R199] up from bed and 'slammed onto w/c' then took [R199] to the toilet and again shoved against toilet very rough. Patient expressed concerns to writer she did not want to report it. she is afraid of retaliation." The grievance resolution, dated 1/10/12 contained the following Solution/Plan of Correction: "ADON [assistant director of nursing] spoke with resident regarding [R199's] grievance. she restated what's written on reverse side. ADON-TCU [transitional care unit] called the two male NARs on duty on said date and time. Both denies any recollection of going into resident's room to provide care but both said they did not and could not do what resident alleged. D/T [due to] resident's description of alleged NAR fitting one of the NARs, he will be instructed not to go into the residents room to provide cares for her." The administrator acknowledged in an interview at 3:04 p.m. on 2/2/12 that she was not immediately notified of the above incident, nor was the incident immediately reported to the SA. During this same interview, ADON-B explained that he usually followed up regarding incidents within 24 hours. However, this incident was not followed up on until 1/10/12 due to 1/7/12 being on a weekend. Further documentation regarding an investigation of this incident was requested during the survey, but was not provided. At 8:30 a.m. on 2/03/12 the administrator acknowledged that the facility's Abuse Prevention Plan policy was not followed regarding reporting and investigation of alleged incidents of abuse.	F 225		

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F 225	Continued From page 4 A grievance report for R345, dated 11/4/11 was reviewed. Document review revealed the following grievance brought forth by the resident's family member: "Resident was crying to [family member] that the aide used [R345's] diaper to transfer [R345] on the toilet and not the transfer belt. Family reported the aide hurt [R345's] back when transferring [R345] on the toilet. The aide left [R345] in her wheelchair by the foot of the bed and [R345] could not reach [R345's] call light." The grievance resolution contained the following solution/plan of correction: "ADON-TCU visited resident in room on 11/4/11, she was lying in bed with [family member] at bedside. She denies any pain or discomfort. [Family member] was informed NAR denies transferring resident without a transfer belt. NAR also said he had call light within reach of resident but resident's phone was inadvertently left out of reach. ADON-TCU attempted to reassure [family member], he would ensure resident gets good care while at MLCC but [family member] had already decided to have res d/c [resident discharged] home stating, 'Me and you have time, but [R345] does not.'" During an interview, at 3:04 p.m. on 2/2/12, ADON-B confirmed the incident had not been reported to the SA. He explained that "Per my notes, within 30 minutes of this being reported the aide was noted to be wearing a transfer belt, so I felt he used the transfer belt." ADON-B further noted he may have decided to report to the SA if the resident continued to have pain when re-interviewed. Further documentation was requested regarding investigation of the incident, however, was not provided.	F 225		

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F 225	Continued From page 5 The facility's Abuse Prevention Plan (revised 7/11), directed staff to immediately investigate and report to the state agency and the administrator any incidents of potential abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown origin.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies were consistent with required immediate reporting of allegations of mistreatment to the designated State agency and thoroughly investigate alleged abuse for 3 of 5 residents (R19, R199, and R345) whose grievance reports reviewed, and to immediately notify administrator 1 of 5 grievance reports reviewed. This had the potential to affect all residents residing in the facility. Findings include: The facility's Abuse Prevention Plan (revised 7/11) directed staff to immediately investigate and report to the State Agency and the administrator any incidents of potential abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown origin. A grievance report for R19 dated 8/15/11,	F 226	R199 discharged on 01/26/12. R345 discharged on 11/04/11. The facility did report to State agency on 08/23/11 & 10/18/11 regarding R19 and State Agency determined that no further action was necessary. R19 was discharged on 01/01/2012. The Administrator and DON will audit all Quality Input Forms (grievance) reports to ensure investigation, notification and reporting to State Agency is completed per our revised policy. The facility will continue to investigate all potential maltreatment reports per our revised policy. The Vulnerable Adult – Abuse Prohibition Plan was reviewed and revised on 02/29/12. Staff will be re-educated about the Vulnerable Adult – Abuse Prohibition Plan including investigation, notifying the administrator, and reporting to State Agency by 03/07/12.	03/09/12

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F 226	Continued From page 6 revealed R19's family member reported: "Unexplainable bruise on (L) [left] breast, (L) [left] upper lower arm and above the waist (L) [left] side. Family not notified." The section for grievance resolution was left blank. A progress note for R19 dated 8/15/11, revealed the following: "[Family member] called this writer to the resident's room to assess the bruises she discovered on the resident's left side. Per [family member] she discovered the bruises while she was helping the resident try on a new outfit. Writer noted 26 cm (centimeter) by 6.5 cm bruise by the left breast area, a 16 cm by 13 cm bruise on the inner upper left arm and a 13 cm by 9 cm bruise on the left side above the waist area. All bruises appeared purplish in color...[family member] upset that the family had not been notified of any incident that lead to these bruises. Resident denied falling and could not recall if she ever pumped [sic] on anything..Response: Will continue to monitor and investigate what led to these bruises." R19's physician's progress note dated 8/23/11 revealed the following impression and plan: "Bruising left chest wall and left arm/no history of fall; doubt rib fracture; no need for x-ray at this time; etiology uncertain but to be investigated." The administrator was interviewed at 9:05 a.m. on 2/3/12. She stated a former staff member investigated the incident and believed the bruises were due to a recent change in transferring methods for R19. The facility decided after the investigation not to report the incident to the SA. Although the investigative documenting investigation was requested, but was not provided	F 226	On 02/01/12, the facility implemented, Truthpoint Satisfaction Surveys, which asks questions pertaining to potential maltreatment. This is completed quarterly for long term care residents and upon admission and discharge for our short term residents. Random staff interviews will be performed by the Administrator or designee for three months to assure that staff understand the Vulnerable Adult – Abuse Prohibition Plan. All Quality Input Forms and investigation of potential maltreatment reports will be reviewed by the Administrator and DON to ensure compliance. The Administrator is responsible for compliance. A summary of the Quality Input Forms and investigation of potential maltreatment reports will be presented to the Quality Assurance Committee each month and the recommendations from the Committee will be followed.	

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F 226	Continued From page 7 to the surveyor for review. A grievance report filed by R199, dated 1/7/12, revealed: "Patient c/o [complained of] an incident that happened last NOC [night]. Called for help to go to the bathroom and a male NAR [nursing assistant] came in to help without saying anything. He got [R199] up from bed and 'slammed onto w/c' then took [R199] to the toilet and again shoved against toilet very rough. Patient expressed concerns to writer she did not want to report it. she is afraid of retaliation." The grievance resolution, dated 1/10/12 contained the following Solution/Plan of Correction: "ADON [assistant director of nursing] spoke with resident regarding [R199's] grievance. she restated what's written on reverse side. ADON-TCU [transitional care unit] called the two male NARs on duty on said date and time. Both denies any recollection of going into resident's room to provide care but both said they did not and could not do what resident alleged. D/T [due to] resident's description of alleged NAR fitting one of the NARs, he will be instructed not to go into the residents room to provide cares for her." The administrator acknowledged in an interview at 3:04 p.m. on 2/2/12 that she was not immediately notified of the above incident, nor was the incident immediately reported to the SA. ADON-B explained that he usually followed up regarding incidents within 24 hours. However, this incident was not followed up on until 1/10/12 due to 1/7/12 being on a weekend. Further documentation regarding an investigation of this incident was requested during the survey, but was not provided.	F 226		

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F 226	Continued From page 8 At 8:30 a.m. on 2/03/12 the administrator acknowledged that the facility's Abuse Prevention Plan policy was not followed regarding reporting and investigation of alleged incidents of abuse. A grievance report for R345, dated 11/4/11 was reviewed. Document review revealed the following grievance brought forth by the resident's family member: "Resident was crying to [family member] that the aide used [R345's] diaper to transfer [R345] on the toilet and not the transfer belt. Family reported the aide hurt [R345's] back when transferring [R345] on the toilet. The aide left [R345] in her wheelchair by the foot of the bed and [R345] could not reach [R345's] call light." The grievance resolution contained the following solution/plan of correction: "ADON-TCU visited resident in room on 11/4/11, she was lying in bed with [family member] at bedside. She denies any pain or discomfort. [Family member] was informed NAR denies transferring resident without a transfer belt. NAR also said he had call light within reach of resident but resident's phone was inadvertently left out of reach. ADON-TCU attempted to reassure [family member], he would ensure resident gets good care while at MLCC but [family member] had already decided to have res d/c [resident discharged] home stating, 'Me and you have time, but [R345] does not.'" During an interview, at 3:04 p.m. on 2/2/12, ADON-B confirmed the incident had not been reported to the SA. He explained that "Per my notes, within 30 minutes of this being reported the aide was noted to be wearing a transfer belt, so I felt he used the transfer belt." ADON-B further noted he may have decided to report to	F 226		

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F 226	Continued From page 9 the SA if the resident continued to have pain when re-interviewed. Further documentation was requested regarding investigation of the incident, however, was not provided. During an interview at 11:00 a.m. on 2/2/12 the administrator explained that the facility conducted initial investigations, and then report to the SA within 24 hours. The administrator explained that depending on the situation, incidents involving residents who made repeated allegations may not have been reported to the SA. During an interview at 12:01 p.m. on 2/2/12 the DON explained that the facility had up to 24 hours to investigate an injury of unknown origin before notifying the SA. During an interview at 3:05 p.m. on 2/2/12, the DON explained that factors considered while initially investigating a complaint included: resident behavioral issues, whether the resident had recently requested discharge, the mental status of resident, history of staff member caring for resident, if there was a mark or injury on the body, what medications the resident was taking, and whether the allegation may be due to discriminatory beliefs about staff members. The DON explained that allegations from residents with behavioral issues may not be called in unless there was a pattern of complaints involving other residents and the alleged perpetrator. During an interview at 6:35 p.m. on 2/2/12, RN-A explained that it was his understanding the facility had up to 24 hours to initially investigate injuries of unknown origin before reporting to the SA.	F 226		

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F 226	Continued From page 10 During an interview at 5:55 p.m. on 2/2/12, LPN-A said she also understood the facility had up to 24 hours to investigate allegations of abuse or injuries of unknown origin before reporting to the SA.	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it is unknown if proper care or services were provided to 1 of 3 residents (R68) to manage urinary incontinence because the resident lacked a comprehensive bladder assessment. Findings include: R68 was noted to have a decline in continence on a significant change Minimum Data Set (MDS) assessment, and was not comprehensively	F 274	R68's Bladder Assessment was reassessed on 02/28/2012. Her care plan was reviewed to ensure appropriate management of urinary incontinence. All residents with a significant change MDS assessment within the previous month will be audited. Bladder assessments and care plans will be reviewed and revised as needed by 03/07/12. The facility bowel and bladder assessment policy will be reviewed by the members of the Interdisciplinary team by 03/07/12. For the next three months, bladder assessments and care plans will be randomly audited (3 per month) for residents with a significant change MDS by the Interdisciplinary Team at IDT meeting. The Director of Nursing is responsible for compliance. The results of the audits will be reported to the Quality Assurance Committee and the Committee's recommendations will be followed.	03/09/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 274	Continued From page 11 reassessed for contributing factors related to incontinence. R68 was admitted to the facility on 9/4/11. The resident's admission MDS indicated the resident was always continent of bladder and needed limited assistance from one person to use the toilet. The care area assessment (CAA) for urinary incontinence indicated the resident's need for assistance was related to psychiatric problems, history of stroke, immobility and antidepressant use. The assessment indicated the resident did not need a toileting treatment program or intervention. A bladder assessment form completed 8/31/11 indicated the resident was currently continent of bladder and no further assessment was indicated. A significant change MDS was initiated on 12/5/11. R68's continence status was changed to "occasionally incontinent of bladder" and need for extensive assistance from one person to use the toilet. The CAA for urinary incontinence indicated that the resident had functional incontinence related to immobility. The assessment indicated R68 was occasionally incontinent and received regular assistance to use the toilet. The CAA noted that the R68's care plan would be revised to ensure the resident's needs were met. A bladder assessment form completed 12/5/11 indicated there was no change in the resident's continence status and no further assessment would be required. A review of the resident's care plan dated	F 274		

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F 274	Continued From page 12 12/22/11 found that there was no area that addressed urinary incontinence or bladder care. An interview with registered a nursing assistant (NA-A) at 6:15 p.m. on 2/2/12 revealed that R68 could use the call light to communicate her need to use the toilet, but was occasionally incontinent when offered assistance. The NA stated toileting was offered to R68 every two hours and the resident wore a brief at all times. An interview with NAR-B at 8:30 a.m. on 2/3/12, also confirmed R68 was incontinent at times, required assistance to toilet every two hours, and wore an incontinent brief at all times. A registered nurse (RN-A) was interviewed at 6:30 p.m. on 2/2/12, and confirmed that R68 did not have a comprehensive bladder reassessment or care plan related to incontinence. The MDS director (RN-MDS) was interviewed at 9:30 a.m. on 2/3/12. RN-MDS confirmed R68 was lacking a comprehensive bladder assessment that reflected the changes noted on the resident's significant change MDS. RN-MDS indicated that the MDS coordinator would have been responsible for revising the resident's assessment after a change occurred in the resident's continence status. RN-MDS stated a care plan reflecting the resident's needs and toileting schedule would be initiated immediately. A review of the facility's policy on Bowel and Bladder Assessment dated January 2009 indicated that residents who were noted to have a change in continence would have a new bladder assessment completed. The nurse was to	F 274		

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F 274	Continued From page 13 implement an individualized toileting schedule based on the assessment, and the care plan would be developed to include goals and interventions for elimination at the highest level of function possible.	F 274		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it is unknown if proper care or services were provided to 1 of 3 residents (R68) to manage urinary incontinence because the resident lacked a comprehensive bladder assessment. Findings include: R68 was noted to have a decline in continence on a significant change Minimum Data Set (MDS) assessment, and was not comprehensively reassessed for contributing factors related to incontinence. R68 was admitted to the facility on 9/4/11. The	F 315	R68's Bladder Assessment was reassessed on 02/28/2012. Her care plan was reviewed to ensure appropriate management of urinary incontinence. All residents with a significant change MDS assessment within the previous month will be audited. Bladder assessments and care plans will be reviewed and revised as needed by 03/07/12. The facility bowel and bladder assessment policy will be reviewed by the members of the Interdisciplinary team by 03/07/12. For the next three months, bladder assessments and care plans will be randomly audited (3 per month) for residents with a significant change MDS by the Interdisciplinary Team at IDT meeting. The Director of Nursing is responsible for compliance. The results of the audits will be reported to the Quality Assurance Committee and the Committee's recommendations will be followed.	03/09/12

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F 315	Continued From page 14 resident's admission MDS indicated the resident was always continent of bladder and needed limited assistance from one person to use the toilet. The care area assessment (CAA) for urinary incontinence indicated the resident's need for assistance was related to psychiatric problems, history of stroke, immobility and antidepressant use. The assessment indicated the resident did not need a toileting treatment program or intervention. A bladder assessment form completed 8/31/11 indicated the resident was currently continent of bladder and no further assessment was indicated. A significant change MDS was initiated on 12/5/11. R68's continence status was changed to "occasionally incontinent of bladder" and need for extensive assistance from one person to use the toilet. The CAA for urinary incontinence indicated that the resident had functional incontinence related to immobility. The assessment indicated R68 was occasionally incontinent and received regular assistance to use the toilet. The CAA noted that the R68's care plan would be revised to ensure the resident's needs were met. A bladder assessment form completed 12/5/11 indicated there was no change in the resident's continence status and no further assessment would be required. A review of the resident's care plan dated 12/22/11 found that there was no area that addressed urinary incontinence or bladder care. An interview with registered a nursing assistant	F 315		

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F 315	Continued From page 15 (NA-A) at 6:15 p.m. on 2/2/12 revealed that R68 could use the call light to communicate her need to use the toilet, but was occasionally incontinent when offered assistance. The NA stated toileting was offered to R68 every two hours and the resident wore a brief at all times. An interview with NAR-B at 8:30 a.m. on 2/3/12, also confirmed R68 was incontinent at times, required assistance to toilet every two hours, and wore an incontinent brief at all times. A registered nurse (RN-A) was interviewed at 6:30 p.m. on 2/2/12, and confirmed that R68 did not have a comprehensive bladder reassessment or care plan related to incontinence. The MDS director (RN-MDS) was interviewed at 9:30 a.m. on 2/3/12. RN-MDS confirmed R68 was lacking a comprehensive bladder assessment that reflected the changes noted on the resident's significant change MDS. RN-MDS indicated that the MDS coordinator would have been responsible for revising the resident's assessment after a change occurred in the resident's continence status. RN-MDS stated a care plan reflecting the resident's needs and toileting schedule would be initiated immediately. A review of the facility's policy on Bowel and Bladder Assessment dated January 2009 indicated that residents who were noted to have a change in continence would have a new bladder assessment completed. The nurse was to implement an individualized toileting schedule based on the assessment, and the care plan would be developed to include goals and interventions for elimination at the highest level of	F 315		

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F 315	Continued From page 16 function possible.	F 315		

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/02/2012**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Martin Luther Manor, 1984 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Martin Luther Manor is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 134 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/02/2012**

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	245272	A. BUILDING **03 - NEW RESIDENCE** B. WING _____	**02/02/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Martin Luther Manor, 2010 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Martin Luther Manor is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 134 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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	245272	A. BUILDING 04 - ADMINISTRATION AND AS B. WING _____	02/02/2012

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5011

February 17, 2012

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minnesota 55425

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5272021

Dear Ms. Barney:

The above facility was surveyed on January 31, 2012 through February 3, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

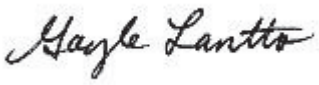
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5272s12lic.rtf

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 31 to February 3, 2012 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced	2 545		

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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) COMPLETE DATE
2 545	Continued From page 2 by: Based on observation, interview and document review, it is unknown if proper care or services were provided to 1 of 3 residents (R68) to manage urinary incontinence because the resident lacked a comprehensive bladder assessment. Findings include: R68 was noted to have a decline in continence on a significant change Minimum Data Set (MDS) assessment, and was not comprehensively reassessed for contributing factors related to incontinence. R68 was admitted to the facility on 9/4/11. The resident's admission MDS indicated the resident was always continent of bladder and needed limited assistance from one person to use the toilet. The care area assessment (CAA) for urinary incontinence indicated the resident's need for assistance was related to psychiatric problems, history of stroke, immobility and antidepressant use. The assessment indicated the resident did not need a toileting treatment program or intervention. A bladder assessment form completed 8/31/11 indicated the resident was currently continent of bladder and no further assessment was indicated. A significant change MDS was initiated on 12/5/11. R68's continence status was changed to "occasionally incontinent of bladder" and need for extensive assistance from one person to use the toilet. The CAA for urinary incontinence indicated that the resident had functional incontinence related to immobility. The assessment indicated	2 545		

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	00227	A. BUILDING _____ B. WING _____	02/03/2012

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2 545	Continued From page 3 R68 was occasionally incontinent and received regular assistance to use the toilet. The CAA noted that the R68's care plan would be revised to ensure the resident's needs were met. A bladder assessment form completed 12/5/11 indicated there was no change in the resident's continence status and no further assessment would be required. A review of the resident's care plan dated 12/22/11 found that there was no area that addressed urinary incontinence or bladder care. An interview with registered a nursing assistant (NA-A) at 6:15 p.m. on 2/2/12 revealed that R68 could use the call light to communicate her need to use the toilet, but was occasionally incontinent when offered assistance. The NA stated toileting was offered to R68 every two hours and the resident wore a brief at all times. An interview with NAR-B at 8:30 a.m. on 2/3/12, also confirmed R68 was incontinent at times, required assistance to toilet every two hours, and wore an incontinent brief at all times. A registered nurse (RN-A) was interviewed at 6:30 p.m. on 2/2/12, and confirmed that R68 did not have a comprehensive bladder reassessment or care plan related to incontinence. The MDS director (RN-MDS) was interviewed at 9:30 a.m. on 2/3/12. RN-MDS confirmed R68 was lacking a comprehensive bladder assessment that reflected the changes noted on the resident's significant change MDS. RN-MDS indicated that the MDS coordinator would have been responsible for revising the resident's assessment after a change occurred in the	2 545		

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2 545	Continued From page 4 resident's continence status. RN-MDS stated a care plan reflecting the resident's needs and toileting schedule would be initiated immediately. A review of the facility's policy on Bowel and Bladder Assessment dated January 2009 indicated that residents who were noted to have a change in continence would have a new bladder assessment completed. The nurse was to implement an individualized toileting schedule based on the assessment, and the care plan would be developed to include goals and interventions for elimination at the highest level of function possible. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise the policies and procedures for completing comprehensive assessments after a significant change for a resident has occurred. Policies and procedures could then be reviewed by all staff and audits could be performed to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 545		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates	2 910		

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2 910	Continued From page 5 that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, it is unknown if proper care or services were provided to 1 of 3 residents (R68) to manage urinary incontinence because the resident lacked a comprehensive bladder assessment. Findings include: R68 was noted to have a decline in continence on a significant change Minimum Data Set (MDS) assessment, and was not comprehensively reassessed for contributing factors related to incontinence. R68 was admitted to the facility on 9/4/11. The resident's admission MDS indicated the resident was always continent of bladder and needed limited assistance from one person to use the toilet. The care area assessment (CAA) for urinary incontinence indicated the resident's need for assistance was related to psychiatric problems, history of stroke, immobility and antidepressant use. The assessment indicated the resident did not need a toileting treatment program or intervention. A bladder assessment form completed 8/31/11 indicated the resident was currently continent of	2 910		

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2 910	Continued From page 6 bladder and no further assessment was indicated. A significant change MDS was initiated on 12/5/11. R68's continence status was changed to "occasionally incontinent of bladder" and need for extensive assistance from one person to use the toilet. The CAA for urinary incontinence indicated that the resident had functional incontinence related to immobility. The assessment indicated R68 was occasionally incontinent and received regular assistance to use the toilet. The CAA noted that the R68's care plan would be revised to ensure the resident's needs were met. A bladder assessment form completed 12/5/11 indicated there was no change in the resident's continence status and no further assessment would be required. A review of the resident's care plan dated 12/22/11 found that there was no area that addressed urinary incontinence or bladder care. An interview with registered a nursing assistant (NA-A) at 6:15 p.m. on 2/2/12 revealed that R68 could use the call light to communicate her need to use the toilet, but was occasionally incontinent when offered assistance. The NA stated toileting was offered to R68 every two hours and the resident wore a brief at all times. An interview with NAR-B at 8:30 a.m. on 2/3/12, also confirmed R68 was incontinent at times, required assistance to toilet every two hours, and wore an incontinent brief at all times. A registered nurse (RN-A) was interviewed at 6:30 p.m. on 2/2/12, and confirmed that R68 did not have a comprehensive bladder reassessment	2 910		

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2 910	Continued From page 7 or care plan related to incontinence. The MDS director (RN-MDS) was interviewed at 9:30 a.m. on 2/3/12. RN-MDS confirmed R68 was lacking a comprehensive bladder assessment that reflected the changes noted on the resident's significant change MDS. RN-MDS indicated that the MDS coordinator would have been responsible for revising the resident's assessment after a change occurred in the resident's continence status. RN-MDS stated a care plan reflecting the resident's needs and toileting schedule would be initiated immediately. A review of the facility's policy on Bowel and Bladder Assessment dated January 2009 indicated that residents who were noted to have a change in continence would have a new bladder assessment completed. The nurse was to implement an individualized toileting schedule based on the assessment, and the care plan would be developed to include goals and interventions for elimination at the highest level of function possible. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure residents who have a decline in urinary status have comprehensive assessments to determine the cause, and plans to restore status put into place. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 910		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults	21990		

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21990	Continued From page 8 Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the designated State agency and thoroughly investigate alleged abuse for 3 of 5 grievance reports reviewed, and to immediately notify administrator of alleged abuse for 1 of 5 grievance reports reviewed. Findings include: The facility produced only three incidents of alleged abuse, neglect, misappropriation of funds and/or injuries of unknown origin that were investigated for the previous year. Grievance reports were reviewed and were not investigated. A grievance report for R19 dated 8/15/11,	21990		

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21990	Continued From page 9 revealed R19's family member reported: "Unexplainable bruise on (L) [left] breast, (L) [left] upper lower arm and above the waist (L) [left] side. Family not notified." The section for grievance resolution was left blank. A progress note, dated 8/15/11 revealed the following: "[Family member] called this writer to the resident's room to assess the bruises she discovered on the resident's left side. Per [family member] she discovered the bruises while she was helping the resident try on a new outfit she brought for (R19). Writer noted 26 cm (centimeter) by 6.5 cm bruise by the left breast area, a 16 cm by 13 cm bruise on the inner upper left arm and a 13 cm by 9 cm bruise on the left side above the waist area. All bruises appeared purplish in color...[family member] upset that the family had not been notified of any incident that lead to these bruises. Resident denied falling and could not recall if she ever pumped [sic] on anything..Response: Will continue to monitor and investigate what led to these bruises." R19's physician's progress note dated 8/23/11 revealed the following impression and plan: "Bruising left chest wall and left arm/no history of fall; doubt rib fracture; no need for x-ray at this time; etiology uncertain but to be investigated." The administrator was interviewed at 9:05 a.m. on 2/3/12. She stated a former staff member investigated the incident and believed the bruises were due to a recent change in transferring methods. The facility decided after the investigation not to report the incident to the SA. Although the investigative documenting investigation was requested, but was not provided to the surveyor for review.	21990		

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21990	Continued From page 10 A grievance report filed by R199, dated 1/7/12, revealed: "Patient c/o [complained of] an incident that happened last NOC [night]. Called for help to go to the bathroom and a male NAR [nursing assistant] came in to help without saying anything. He got [R199] up from bed and 'slammed onto w/c' then took [R199] to the toilet and again shoved against toilet very rough. Patient expressed concerns to writer she did not want to report it. she is afraid of retaliation." The grievance resolution, dated 1/10/12 contained the following Solution/Plan of Correction: "ADON [assistant director of nursing] spoke with resident regarding [R199's] grievance. she restated what's written on reverse side. ADON-TCU [transitional care unit] called the two male NARs on duty on said date and time. Both denies any recollection of going into resident's room to provide care but both said they did not and could not do what resident alleged. D/T [due to] resident's description of alleged NAR fitting one of the NARs, he will be instructed not to go into the residents room to provide cares for her." The administrator acknowledged in an interview at 3:04 p.m. on 2/2/12 that she was not immediately notified of the above incident, nor was the incident immediately reported to the SA. During this same interview, ADON-B explained that he usually followed up regarding incidents within 24 hours. However, this incident was not followed up on until 1/10/12 due to 1/7/12 being on a weekend. Further documentation regarding an investigation of this incident was requested during the survey, but was not provided. At 8:30 a.m. on 2/03/12 the administrator acknowledged that the facility's Abuse Prevention Plan policy was not followed regarding reporting	21990		

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21990	Continued From page 11 and investigation of alleged incidents of abuse. A grievance report for R345, dated 11/4/11 was reviewed. Document review revealed the following grievance brought forth by the resident's family member: "Resident was crying to [family member] that the aide used [R345's] diaper to transfer [R345] on the toilet and not the transfer belt. Family reported the aide hurt [R345's] back when transferring [R345] on the toilet. The aide left [R345] in her wheelchair by the foot of the bed and [R345] could not reach [R345's] call light." The grievance resolution contained the following solution/plan of correction: "ADON-TCU visited resident in room on 11/4/11, she was lying in bed with [family member] at bedside. She denies any pain or discomfort. [Family member] was informed NAR denies transferring resident without a transfer belt. NAR also said he had call light within reach of resident but resident's phone was inadvertently left out of reach. ADON-TCU attempted to reassure [family member], he would ensure resident gets good care while at MLCC but [family member] had already decided to have res d/c [resident discharged] home stating, 'Me and you have time, but [R345] does not.'" During an interview, at 3:04 p.m. on 2/2/12, ADON-B confirmed the incident had not been reported to the SA. He explained that "Per my notes, within 30 minutes of this being reported the aide was noted to be wearing a transfer belt, so I felt he used the transfer belt." ADON-B further noted he may have decided to report to the SA if the resident continued to have pain when re-interviewed. Further documentation was requested regarding investigation of the incident, however, was not provided. The facility's Abuse Prevention Plan (revised	21990		

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21990	Continued From page 12 7/11), directed staff to immediately investigate and report to the state agency and the administrator any incidents of potential abuse, neglect, mistreatment, misappropriation of resident property and injuries of unknown origin. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		