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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: INN0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245399**

2.STATE VENDOR OR MEDICAID NO.
(L2) **615542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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 **04/02/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Sarah Grebenc, Unit Supervisor May 29, 2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen Leach, Program Specialist May 29,2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2013
(L33)

DETERMINATION APPROVAL

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

Post Certification Revisit, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 15, 2013, the facility is certified for 55 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5399 May 29, 2013

Mr. Scot Allen, Administrator
Lutheran Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

Dear Mr. Allen:

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 15, 2013, the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Scot Allen, Administrator
Lutheran Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

May 29, 2013

RE: Project Number S5399023

Dear Mr. Allen:

On February 28, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 14, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 2, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 21, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 14, 2013, effective March 15, 2013 and therefore remedies outlined in our letter to you dated February 28, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Enclosure
cc: Licensing and Certification File

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
245399	A. Building B. Wing	4/2/2013

Name of Facility	Street Address, City, State, Zip Code
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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 **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **03/06/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/15/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/06/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/15/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/15/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/15/2013**	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:
	SG/cbl	05/29/2013	28589	04/02/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		
2/14/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245399	A. Building B. Wing **01 - MAIN BUILDING 01**	3/21/2013

Name of Facility	Street Address, City, State, Zip Code
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/13/2013**	ID Prefix	Correction Completed **03/13/2013**	ID Prefix	Correction Completed **02/14/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0029		LSC K0038	
ID Prefix	Correction Completed **02/18/2013**	ID Prefix	Correction Completed **02/28/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0052		LSC K0056		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	05/29/2013	27200	03/21/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/13/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: INN0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245399**

2.STATE VENDOR OR MEDICAID NO.
(L2) **615542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHERAN CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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	IID
	55			
(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 :
Nicolle Marx, HFE-NEII 03/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 04/07/2013 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5399
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) 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 after March 15, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6287

February 28, 2013

Mr. Scot Allen, Administrator
Lutheran Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

RE: Project Number S5399023

Dear Mr. Allen:

On February 14, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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:

Sarah Grebenc
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7365

Fax: (320) 223-7348

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 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 26, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that 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 14, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2013 (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,

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

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
	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 RECEIVED MAR 14 2013 MN Dept of Health St. Cloud 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 response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure resident fund accounts were insured with a surety bond. This affected 38 of the 45 current residents who had a fund account managed by the facility. Findings include: During an interview on 02/13/13, at 2:40 p.m., the facility administrator and the business office manager (BOM), who was interviewed by telephone, were asked to provide evidence of a surety bond for the resident fund accounts managed by the facility. Both the administrator and BOM were unaware whether the facility had purchased a surety bond in the amount equal to	F 161	**F 161 SURETY BOND** Facility assures security of all residents' personal funds deposited with the facility. At the time of survey, the facility provided verification of personal fund security through property insurance and fiduciary insurance. The facility does maintain a specific Surety Bond for resident trust funds which was located after survey in an off-site management company file. *Identified & Other Potential Residents:* The facility has and will maintain a Surety Bond to cover all resident personal funds deposited with the facility.	

OK 3.25.13 SG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Allen	ADMINISTRATOR	MARCH 13, 2013

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING _____ B. WING _____	02/14/2013

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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 February 11, 12, 13, and 14, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were 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,	2 000	RECEIVED MAR 14 2013 MN Dept of Health St.Cloud 3.25.13 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.	

Minnesota Department of Health

Scott Allen — TITLE: Administrator — (X6) DATE: March 13, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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F 161	Continued From page 1 or greater than personal funds held by the facility. The administrator stated that he would check further with the facility's insurance and banking representatives and verify this information. At the time of survey exit, on 02/14/2013, at 4:30 p.m., no further information was provided.	F 161	*Systematic Changes:* Business Office staff reminded to maintain the Surety Bond in an inspection accessible location and to assure continued coverage when due for renewal.	
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 interview and document review the facility failed to develop a care plan related to fall risk and interventions for 1 of 3 residents (R17) reviewed for accidents.	F 279	*Auditing/Monitoring:* Administrator will monitor for compliance. *Completion Date:* March 6, 2013 **F279** **COMPREHENSIVE CARE PLANS** Facility does use assessment results to develop, review and revise resident's comprehensive plan of care. *Identified Resident:* R17's fall risk was assessed by the facility's Inter-disciplinary Team (IDT) prior to and again during survey and the comprehensive plan of care was reviewed and revised by the resident's RN Case Manager to address fall risk and interventions. *Other Potential Residents:* The process of care plan updating was reviewed with licensed nursing staff during the survey by nursing administration & surveyors. RN staff	

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F 279	Continued From page 2 Findings include: R17 was admitted to the facility on 12/13/12, and had diagnoses which included but were not limited to dementia and muscle weakness. R17 had falls on 1/1/13, 1/21/13, and 2/2/13. The nursing assistant care sheet for the wing where R17 resided was blank under R17's fall prevention interventions section. Review of R17's care plan last updated 1/1/13, did not identify the risk for falls nor any interventions to prevent further falls. During interview on 2/14/13, at 9:55 a.m., the director of nursing (DON) indicated when a resident fell the nursing assistant care sheet and care plans would be updated immediately. The DON was unable to identify if any interventions had been put into place after any of R17's falls and stated the fall reports would have that information. DON reviewed R17's care plan and nursing assistant care sheet and confirmed the lack of identification of fall risk status or any interventions to prevent future falls. Review of the facility's policy, "Care Plan Guide For Nursing" dated 05/04, revealed written individualized care plans would be developed and revised for each resident for all staff to use. Review of the facility's policy, "Care Plans-Comprehensive" date 04/05, revealed each resident's comprehensive care plan would be designed to incorporate identified problem areas and incorporate risk factors associated with	F 279	reviewed residents at risk for falls during survey to assure the care plans addressed risk & interventions. *Systematic Changes:* Licensed nursing staff educated on using results of assessment to develop, review and revise each resident's care plan. The facility's IDT reviews accidents on a weekday basis and will confirm that care plans are updated to address resident issues. *Auditing/Monitoring:* RN Charge or designee will audits 2 care plans per week in conjunction with care conferences (when available) for the next 8 weeks to assure compliance. The Director of Nursing or designee will review audits and report to the facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* March 13, 2013	

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F 279	Continued From page 3 identified problems.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and implement interventions to minimize falls for 1 of 3 residents (R17) reviewed for accidents. Furthermore, the facility failed to ensure that chemicals were properly stored in 1 of 2 tub rooms. This had the potential to affect three cognitively impaired residents who resided near the tub room. Findings include: R17 had sustained three falls since admission to the facility, the facility did not identify or implement any fall prevention interventions. R17 was admitted to the facility on 12/13/12, and had diagnoses which included but were not limited to dementia and muscle weakness. The admission minimum data set dated 12/26/12, identified R17 was moderately cognitively impaired and required extensive assistance from two staff for bed mobility and transferring.	F 323	**F 323** **FREE OF ACCIDENT HAZARDS** Facility ensures the resident environment is as free of accident hazards as is possible. *Identified Resident & Situation:* R17's fall risk was assessed by the facility IDT prior to and again during survey and the comprehensive plan of care was reviewed and revised by the resident's RN Case Manager to address fall risk and interventions. During survey, chemicals in identified tub room were promptly removed and all tub rooms were checked to verify that no unmarked chemicals were present. *Other Potential Residents:* Care plan updating was reviewed with licensed nursing staff during the survey by surveyors & nursing administration. RN staff reviewed residents during survey to assure those at risk for falls had care plans addressing risk & interventions. *Systematic Changes:* RN Case Managers were reminded and will assure care plans address risks and interventions.	

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F 323	Continued From page 4 R17's care area assessment (CAA) dated 12/22/12, identified the potential for falls related to weakness, impaired balance during transitions, medication use and clinical diagnoses. The CAA indicated falls would be addressed in the care plan and the overall objective was to minimize risk. An incident report dated 1/1/13, noted, "Resident noted on floor upon entering room for routine rounds. Upon entering room, resident is noted to be on his left side on his shoulder and hip in the middle of the room." The report identified, "Only injury noted is a 1 cm [centimeter] in diameter scrape to the right knee with a scant amount of fresh dry blood." The response was, "Resident is resting with eyes closed at this time and has no complaint of pain. Nursing staff will continue to monitor this resident." An incident report dated 1/21/13, noted, "Call light on resident hollering for help. Resident sitting on floor and wheelchair pedal. Resident stated that he slid out of his wheel chair. Did note some scratch marks on his left upper hip. Was assisted by 2 and transfer belt up into his wheelchair." An incident report dated 2/2/13, noted, "Resident wanted to go to bed. Attempted to transfer self and slid out of w/c [wheelchair]. Found sitting on foot pedals of chair with back against the seat. No injuries found." A fall review assessment completed on 1/1/13, indicated R17's Fall Care Plan had been reviewed and included needs and preferences which identified the interventions and approaches	F 323	Staff were reminded at a 2/19/13 All Staff Meeting of the facility's policy that all chemicals in the facility must be pre-approved & marked and cupboards & tub room doors are to be locked. *Auditing/Monitoring:* RN Charge or designee will audits 2 care plans per week in conjunction with care conferences (when available) and tub rooms weekly for the next 8 weeks to assure compliance. The Director of Nursing or designee will review audits and report to the facility's QA Committee for review and input. *Completion Date:* March 15, 2013	

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F 323	Continued From page 5 were effective in fall prevention. The nursing assistant care sheet for the wing where R17 resided was blank under R17's fall prevention interventions section. Review of R17's care plan last updated 1/1/13, did not identify the risk for falls nor any interventions to prevent further falls. During interview on 2/14/12, at 9:05 a.m., nursing assistant (NA)-A stated R17 could be very difficult at times and would try to transfer alone. NA-A further described R17 as non-compliant and indicated the staff needed to use reminders all the time to call for help. During interview on 2/14/13, at 9:55 a.m., director of nursing (DON) indicated when a resident suffered a fall the nursing assistant care sheet and care plans would be updated immediately. DON was unable to identify if any interventions had been put into place after any of R17's falls and stated the fall reports would have that information. DON reviewed R17's care plan and nursing assistant care sheet and confirmed the lack of identification of fall risk status or any interventions to prevent future falls. Review of the incident reports dated 1/1/13, 1/21/13 and 2/2/13 with administrator on 2/14/13 at 11:09 a.m., revealed that although the incident reports were reviewed in the interdisciplinary team (IDT) meetings, no interventions were put into place to prevent the resident from falling again. Administrator also confirmed no documentation was present which indicated the staff had discussed any risk versus benefits	F 323	*This page intentionally blank.*	

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F 323	Continued From page 6 regarding falling with R17. A policy related to fall assessments and interventions was requested but none provided. During the environmental tour chemicals were observed in the 200 wing tub room which was unlocked and the door was wide open. On 2/13/13, at 1:07 p.m., the tub room on the 200 wing was observed to be unlocked and the door was wide open. A spray bottle of Hillyard Vindicator disinfectant was observed to sit on the sink. Also a plastic saline bottle with no label on it was on the sink. The liquid substance inside was a light red color. At 1:08 p.m. licensed practical nurse (LPN)-A verified the presence of the chemicals on the sink and indicated they should have been locked in the cupboard that was on the wall. LPN-A walked over to cupboard and opened it up, as it was also unlocked at the time. Inside the cupboard was another bottle of the Hillyard Vindicator disinfectant. LPN-A stated the cupboard was supposed to be locked but the keys used to lock the cupboard were not observed to hang on the side like usual. LPN-A then went down the hallway to NA-B and asked her if the tub room door was open so she could give a bath. NA-B stated no, it was open because she was used the Prolift machine which was stored in the tub room. LPN-A proceeded down the hall and entered the room where NA-B was. When LPN-A exited the room, she confirmed NA-B did not know what the light red liquid in the saline bottle was. On 2/13/13, at 1:20 p.m., the DON confirmed the tub room doors should always be closed and	F 323	*This page intentionally blank.*	

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F 323	Continued From page 7 locked. DON was unable to identify the light red liquid in the saline bottle and was unable to explain how the chemicals were supposed to be stored in the tub rooms. The DON verified there were confused residents who resided on the 200 wing who were mobile and potentially could have wandered into the open tub room. Maintenance-A provided the material safety data sheet (MSDS) for the Hillyard Vindicator on 2/13/13, at 3:01 p.m. The MSDS indicated exposure to the Vindicator could cause irreversible eye damage and skin burns. The MSDS further indicated the product should be stored in its original container in areas inaccessible to children. Maintenance-A stated the chemicals in the bathroom should have been stored in the locked cabinet on the wall. During interview on 2/13/13, at 3:30 p.m. the DON indicated she had not yet determined what type of liquid was in the saline bottle. On 2/13/13, at 3:35 p.m., human resources (HR) -A presented the facility's occupational safety and health administration (OSHA) hazardous communication information which was provided to all staff during initial employee training. Number two (e) on the document explains that product labels should contain information on how to shore and dispose of the product. HR-A stated that per the document, staffs were expected to check the manufacturer's label for storage information as guidance for how to handle chemicals in the facility.	F 323	*This page intentionally blank.*	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 8 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility to identify ongoing clinical rationale for the continued use of an anti-depressant for 1 of 10 residents (R2) reviewed for unnecessary medications. Findings include: R2 had diagnoses which included depression. Review of the current signed physician's orders	F 329	**F329** **DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Facility does identify and document clinical rationale for continued use of each resident's drug regimen. *Specific Resident:* The primary MD for R2 has been consulted regarding resident's specific medication, and gradual dose reduction (GDR). The MD discontinued noted medication. Resident behaviors and hallucinations returned and MD reinstated mediation. *Other Potential Residents:* Resident review of unnecessary drugs for residents is completed monthly by the Consulting Pharmacist and Nursing Administration. Residents identified since survey exit have been addressed as necessary. *Systematic Changes:* RN Managers have been reminded of facility policy of reviewing, identifying and documenting clinical rationale for each resident's drug regimen. Facility policy regarding review, action on Consulting Pharmacist's recommendations and GDR were reviewed with appropriate staff.	

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F 329	Continued From page 9 for R2 included an order for Remeron (an antidepressant used to treat major depressive disorder) 7.5 milligrams (mg) orally at bedtime every day for depressive disorder. The quarterly minimum data set (MDS) dated 7/2/12, identified R2 had a severe cognitive impairment, felt tired, felt bad about self and had thoughts of being better off dead or of hurting self in some way, several days during the assessment period. The MDS care area assessment (CAA) dated 9/3/12, identified R2 had little interest in doing things and no changes in mood in past 90 days. The CAA further identified that R2 took an antidepressant for a diagnosis of depression. R2's care plan revised on 12/11/12, identified the use of an antidepressant for depression. The interventions listed included address minimum effective dose regimens with primary medical doctor per facility protocol and give medication as per physician orders for depression. A nursing psychotropic review note dated 1/29/2013, indicated R2 was taking Remeron for depression. The note further identified R2 had a history of weeping however no current episodes had been noted and would update the nurse practitioner that the medication seemed to be working well. The consulting pharmacist conducted a review of R2's drug regimen on 12/27/12, and at that time noted "R2 was due for a GDR [gradual dose reduction] related to Remeron use." Registered nurse (RN)-A responded, "Done 11/27/12." On	F 329	*Auditing/Monitoring:* RN Case Manager or designee will audits care plans 2 times per week in conjunction with care conferences (when available) for the next 8 weeks to assure compliance. The Director of Nursing or designee will review audits and report to the facility's QA Committee for review and input. *Completion Date:* March 15, 2013	

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F 329	Continued From page 10 1/22/13, the consulting pharmacist again reviewed R2's drug regimen and noted, "The only GDR reviews for Remeron I am able to find is from 9/20/12. Has one been done since and is not yet filed in chart? If not further documentation is needed from MD [medical doctor]-specifically why a decrease is contraindicated." RN-A again responded, "GDR done 11/27/12." A GDR for Remeron 7.5 mg was requested for the physician's evaluation on 8/29/12. The physician's response on 9/20/12, was "No changes." During interview on 2/13/13, at 12:10 p.m., RN-A recalled starting a GDR form in the computer related to R2's use of Remeron on 11/27/12, but during review of the electronic chart and paper chart, RN-A was unable to find documentation to show the report had been given to the physician or addressed at any time. RN-A indicated her process was to go back in the electronic chart and update the form after completion and the paper copy was to go in the paper chart under the medication tab so it would not get thinned out, but acknowledged that neither step had been completed in this case and was unable to provide any further information. A policy for gradual dose reductions was requested, however none which identified gradual dose reductions related to antidepressant use was provided.	F 329	*This page intentionally blank.*	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that --	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 334	Continued From page 11 (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	**F334** **INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS** The facility does have a policy and does properly offer and document each residents' influenza immunizations. *Identified Resident:* Resident R1 was offered an influenza immunization and declined. *Other Potential Residents:* RN Case Managers have reviewed each resident's medical record to assure all had been properly offered an influenza immunization. *Systematic Changes:* The facility reminded staff to verify that all residents are properly offered influenza immunizations. *Auditing/Monitoring:* Medical Records Clerk will verify that all residents have received or are offered influenza immunizations upon admission or annually thereafter. Director of Nursing or designee will audit resident's charts to confirm compliance for the next 8 weeks. *Completion Date:* March 6, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 334	Continued From page 12 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure all residents' clinical records contained complete documentation that all residents were offered the influenza immunization for 1 of 7 residents (R1) reviewed for infection control. R1 was admitted to the facility on 8/11/12. The admission minimum data set dated 8/21/12, identified R1 was cognitively intact. During an interview on 2/13/13, at 12:00 p.m., registered nurse (RN)-A, who was responsible for the immunization records, reviewed the electronic	F 334	*This page intentionally blank.*	

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	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 334	Continued From page 13 and paper clinical records and confirmed there was no documentation which identified if R1 had been offered the influenza vaccine. Review of the policy, "Influenza Vaccine" revised 03/03, revealed all residents would be offered the influenza vaccine annually to encourage and promote the benefits associated with immunizations against influenza. Furthermore, appropriate entries must be documented in the residents' medical records indicating the date of the receipt or refusal of the annual influenza vaccination.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to address the consulting pharmacist's recommendations for a taper of an antidepressant medication 1 of 10 residents (R2) reviewed for unnecessary medications. Findings include: Review of the current signed physician's orders	F 428	**F428** **DRUG REGIMEN REVIEW, REPORT** The facility does assure that each resident's drug regimen is reviewed monthly by a licensed pharmacist and any irregularities are reported to the attending physician, the director of nursing and the reports are acted upon. *Specific Resident:* The primary MD for R2 has been consulted regarding resident's specific medication, and gradual dose reduction (GDR). The MD discontinued noted medication. Resident behaviors and hallucinations returned and MD reinstated mediation. *Other Potential Residents:* Resident review for unnecessary drugs for all residents is completed monthly by the Consulting Pharmacist and	

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	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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F 428	Continued From page 14 for R2 included an order for Remeron (an antidepressant used to treat major depressive disorder) 7.5 milligrams (mg) orally at bedtime every day for depressive disorder. The consulting pharmacist conducted a review of R2's drug regimen on 12/27/12, and at that time noted "R2 was due for a GDR [gradual dose reduction] related to Remeron use." Registered nurse (RN)-A responded, "Done 11/27/12." On 1/22/13, the consulting pharmacist again reviewed R2's drug regimen and noted, "The only GDR reviews for Remeron I am able to find is from 9/20/12. Has one been done since and is not yet filed in chart? If not further documentation is needed from MD [medical doctor]-specifically why a decrease is contraindicated." RN-A again responded, "GDR done 11/27/12." A GDR for Remeron 7.5 mg was requested for the physician's evaluation on 8/2912. The physician's response on 9/20/12, was "No changes." During interview on 2/13/13, at 12:10 p.m., RN-A recalled starting a GDR form in the computer related to R2's use of Remeron on 11/27/12, but during review of the electronic chart and paper chart, RN-A was unable to find documentation to show the report had been given to the physician or addressed at any time. RN-A indicated her process was to go back in the electronic chart and update the form after completion and the paper copy was to go in the paper chart under the medication tab so it would not get thinned out, but acknowledged that neither step had been completed in this case and was unable to provide any further information.	F 428	Nursing Administration. All residents have been reviewed since survey exit and addressed as necessary. *Systematic Changes:* RN Managers have been reminded of facility policy of reviewing, identifying and documenting clinical rationale for each resident's drug regimen. Facility policy regarding review, action on Consulting Pharmacist's recommendations and GDR were reviewed with appropriate staff. *Auditing/Monitoring:* RN Nurse Manager or designee will audits care plans 2 times per week in conjunction with care conferences (when available) for the next 8 weeks to assure compliance. The Director of Nursing or designee will review audits and report to the facility's QA Committee for review and input. *Completion Date:* March 15, 2013	

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	245399	A. BUILDING _____ B. WING _____	02/14/2013

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F 428	Continued From page 15 During interview on 2/14/13, at 2:00 p.m., the consulting pharmacist verified the requests for R2's Remeron to be addressed regarding a GDR. The consulting pharmacist indicated the second review was requested appropriately as no documentation was found in the chart which indicated the GDR had been addressed correctly.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441 INFECTION CONTROL** The facility has established and maintained an Infection Control Program designed to provide an environment to help prevent the development and transmission of disease and infection. *Identified Residents:* LPN-A's process was corrected during the medication pass survey observation and the glucometer in question was disinfected before use with another resident. *Systematic Changes:* The facility reviewed its policy and found it to be correct. Licensed nursing staff were reminded of the facility policy of cleaning a facility owned glucometer between each resident use at a Nurses' Staff Meeting on 2/19/13. Specifically identified licensed staff were given individual instruction in this regard. *Audit/Monitoring:* RN Case Managers or designee will audit glucometer use and cleaning methods 2 times per week for 8 weeks to assure proper procedure.	

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	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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F 441	Continued From page 16 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility owned multi-use glucometers (blood glucose meters used to check blood sugar levels) were sanitized between resident use to minimize the risk of transmission of potential blood borne infections for 1 of 2 observations, which affected 2 residents (R88 and R2). Findings include: During observation on 2/11/13, at 4:55 p.m., licensed practical nurse (LPN)-A tested R88's blood sugar with a facility owned Assure Platinum glucometer. After the blood glucose reading was obtained, LPN-A returned to the medication cart, opened the top drawer, and put the glucometer into the drawer. LPN-A then pushed the medication cart to the next resident's (R2) room, who required a blood glucose check. At 5:01 p.m. LPN-A opened the top drawer on the medication cart and removed the same glucometer. LPN-A gathered her supplies and the glucometer, and proceeded into R2's room, and told R2 that she was going to check her blood glucose. At that time, LPN-A was stopped.	F 441	The Director of Nursing or designee will review audits and report to the facility's QA Committee for review and input. *Completion Date:* March 15, 2013	

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F 441	Continued From page 17 During an interview on 2/11/13, at 5:03 p.m., LPN-A stated she did not know if the glucometers needed to be sanitized between residents. LPN-A walked to the nurse's station and looked for a policy book. The director of nursing (DON) was at the nurse's station. LPN-A asked the DON if glucometers needed to be cleaned between residents. The DON stated, "Yes." LPN-A stated, "I learned something new today." During an interview on 2/11/13, at 5:51 p.m., the DON stated infection control education, which included information about the importance of glucometers between residents, was provided to new employees upon hire and annually thereafter. During an interview on 2/11/13, at 6:40 p.m., LPN-A recalled that she received information about infection control when she started at the facility but did not remember if she received information about sanitizing glucometers between residents. LPN-A stated she had, "Never worked anywhere that made you clean the glucometers." The facility's policy, "Recommended Infection-Control and Safe Injection Practices to Prevent Patient-To-Patient Transmission of Bloodborne Pathogens" dated 03/04, by Center for Disease Control and Prevention indicated, "If a glucometer that has been used for one patient must be used for another patient, the device must be cleaned and disinfected." The facility's policy, "Glucometer Cleaning Policy" dated 07/15/10, included, "It is the policy of this facility that glucometers that are shared between	F 441	*This page intentionally blank.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 more than one resident are disinfected between each resident use."	F 441	**F465** **SAFE & SANITARY ENVIRONMENT** The facility does provide a safe, functional, sanitary and comfortable environment for residents, staff and public. *Specific Issues:* The call lights in question were repaired within the hour of notation. The register cover was repaired and replaced prior to the survey exit on 2/14/13. The missing sections of floor tile have been repaired. *Systematic Changes:* Staff will inform Maintenance personnel via the facility work order system of items needing repair. All staff were reminded of the need to forward repair issues during the 2/18/13 All Staff Meeting. *Auditing/Monitoring:* Housekeeping staff will routinely monitor for environmental issues needing repair, including call light operations, as they work throughout the building. Staff will audit one station per week to assure proper call light operation.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide maintenance services in order to maintain a safe and orderly environment related to a baseboard heating unit, a nonfunctioning call light and a bathroom tile floor, this had the potential to affect 3 rooms (217, 212, and 408) reviewed in the sample for environment. Findings include: On 2/11/13, at 4:41 p.m., the call light in the bathroom nor the call light over the bed in room 212 where resident (R)-64 resided were observed to light up in the hallway when tested. The quarterly minimum data set dated 1/18/13, identified R64 was severely cognitively impaired, however was independent with bed mobility, walking in room and toileting. During interview on 2/11/13, at 6:49 p.m., nursing assistant (NA)-C stated R64 occasionally used the call light located over the bed. On 2/11/13, at 7:12 p.m., the administrator indicated the maintenance department	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	02/14/2013

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F 465	Continued From page 19 employees had left for the day, but he would give a call and see if they could get the call light fixed right away. The administrator stated the housekeeping departments were responsible for to check the call lights as part of their duties, but was unsure of the frequency. During the environmental tour on 2/13/13, at 12:48 p.m., maintenance-A confirmed the administrator had called him at home on 2/11/13, to discuss the call light in room 212 and how to fix it. Maintenance-A explained the light bulb above the door was burned out. Maintenance-A described the process for to check the call light function which included only to check the call lights to ensure they were in working order when a new resident moved in. Maintenance-A was sure the call light in room 212 had not been checked for a long time as R64 had resided there for quite some time. The call light audit sheet was provided which dated back to 6/13/12. Room 212 had not been checked during that time. Also during the environmental tour, maintenance-A verified the register cover in room 217 was removed which exposed the piped heating element and needed repair. Maintenance-A suggested that the nursing assistants had probably broken the cover when when the bed was lifted or lowered as the section that was missing lined up with the length of the bed. Maintenance-A indicated the nursing or housekeeping staff should have filled out a yellow form and submitted it to him so he could complete the repair. Maintenance-A confirmed no requests had been made to fix the register and so it was impossible to know how long it had been broken.	F 465	The Director of Environmental Services will review audits and report to the facility's QA Committee for review and input. *Completion Date:* March 15, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 465	Continued From page 20 Furthermore, during the environmental tour, maintenance-A verified two sections of tile on the bathroom floor in room 408 were missing. One section was centered between the toilet and the bathtub and measured approximately two inches by three inches. The other section surrounded the base of the toilet which nearly went all the way around the base and extended out about an inch. The missing areas of tile left the subfloor exposed and maintenance-A indicated the tile on the floor was 45 years old, and the sections that were missing must have been missing for quite some time based on the appearance. Policies regarding the frequency to check call lights, floor maintenance and general repair were requested however, on 2/14/13, at 1:00 p.m., the administrator stated none existed.	F 465	*This page intentionally blank.*	

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

F 5399021

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Lutheran Care Center was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. **K 017 (Gap Penetrations)** **NFPA 101 LIFE SAFETY CODE STANDARD** *Correction:* The noted gap penetrations have been filled and corrected. *Monitoring:* Environmental Services Director will provide on-going monitoring of the building to protect for penetrations. *Completion Date:* March 13, 2013	

DC: 03.26.2013
EXIT: 02.14.2013

RECEIVED
MAR 14 2013
MINNESOTA DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
JB 3-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Keller	Administrator	March 13, 2013

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
	245399	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lutheran Care Center is a 1 story building with no basement. It was constructed at four different times. The original building was built in the 1964 and was determined to be of a Type II(222) construction. In 1975 an addition was added to the east of 200 Wing that was determined to be Type II (222) construction. In 1992 an addition was added to the west of 100 Wing that was determined to be Type II (000) construction. In 2001 an addition was added to the southwest that was determined to be Type II(000). The facility is fully protected by a fire sprinkler system. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces which is monitored for automatic fire department notification. Because the original building and the 3 additions are of the same type of construction type allowed for	K 000	*This page intentionally blank.*	

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	245399	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/13/2013

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K 000	Continued From page 2 existing buildings, the facility was surveyed as one building. The facility has a capacity of 55 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	*This page intentionally blank.*	
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations, the facility had a penetration in the corridors that is not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient practice could affect the exiting of residents, staff and visitors. In	K 017	SEE PAGE 1.	3/13/2013

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K 017	Continued From page 3 the event of a fire in this space, smoke and fire could spread into the corridor making it untenable. Findings include: On facility tour between 9:30 AM to 12:30 PM on 2/13/2013, it was observed that the facility has a 1/2 inch gap penetration around the sprinkler pipe in the corridor outside resident room 318 and a 1 inch gap around the piping located in the corridor outside of resident room 112 This deficient practice was verified by the Environmental Services Manager (BP).	K 017		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101	K 029	**K 029 (Gap Penetration)** **NFPA 101 LIFE SAFETY CODE STANDARD** *Correction:* The noted gap penetration has been filled with approved caulking. *Monitoring:* Environmental Services Director will provide on-going monitoring of the building to protect for penetrations. *Completion Date:* March 13, 2013	

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K 029	Continued From page 4 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 9:30 AM to 12:30 PM on 02/13/2013, observation revealed that there was a penetration around the sprinkler pipe in the 100 wing medication room that was not sealed with approved intumescent calking. This deficient practice was verified by the Environmental Services Manager (BP).	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 . This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:30 PM	K 038	**K 038 (Accessible Exits)** **NFPA 101 LIFE SAFETY CODE STANDARD** *Correction:* Exits were corrected and maintained to be accessible. *Monitoring:* Environmental Services Director will provide on-going monitoring to assure compliance. *Completion Date:* February 14, 2013	

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K 038	Continued From page 5 on 02/13/2013, observation revealed that the following require exits had snow on sidewalk and steps from the exit discharge to the public way: 1) 2 to 6 inches of snow outside of the 100 wing northwest exit, 2) 12 inches of snow outside of the north and south required exits located in the chapel, and 3) 12 inches of snow located outside of the 400 wing east exit. This deficient practice was confirmed by the Environmental Services Manager (BP).	K 038		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could	K 052	**K 052 (Maintained Alarm System)** **NFPA 101 LIFE SAFETY CODE STANDARD** *Correction:* Heat detector reconnected to box. *Monitoring:* Environmental Services Director will provide on-going monitoring to assure compliance. *Completion Date:* February 18, 2013	

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K 052	Continued From page 6 adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 02/13/2013, observation revealed that there was a heat detector the is hanging by the wires located in the kitchen outside the freezer. This deficient practice was verified by the Environmental Services Manager (BP).	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by:	K 056	**K 056 (Maint Sprinkler System)** **NFPA 101 LIFE SAFETY CODE STANDARD** *Correction:* Sprinkler Company replaced the gauge. *Monitoring:* Environmental Services Director will provide on-going monitoring to assure compliance. *Completion Date:* February 28, 2013	

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K 056	Continued From page 7 Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow damage to the sprinkler piping that would cause failures in the system and affect all residents, visitors and staff of the facility. Findings Include: On facility tour between 9:30 AM to 12:30 PM on 02/13/2013, observations reveled that gauges at the fire sprinkler riser were not replaced or recalibrated within the last 5 years. At The time of the inspection the last know date for when the gauges were last last replaced or recalibrated was 03/08/2006. This deficient practice was verified by the Environmental Services Manager (BP).	K 056	*This page intentionally blank.*	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6287

February 28, 2013

Mr. Scot Allen, Administrator
Lutheran Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5399023

Dear Mr. Allen:

The above facility was surveyed on February 11, 2013 through February 14, 2013 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, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. 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,

Sarah Grebenc

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

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
	00382	A. BUILDING _____ B. WING _____	02/14/2013

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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 February 11, 12, 13, and 14, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were 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,	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 Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301.	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.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557,	2 560		

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2 560	Continued From page 2 subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan related to fall risk and interventions for 1 of 3 residents (R17) reviewed for accidents. Findings include: R17 was admitted to the facility on 12/13/12, and had diagnoses which included but were not limited to dementia and muscle weakness. R17 had falls on 1/1/13, 1/21/13, and 2/2/13. The nursing assistant care sheet for the wing where R17 resided was blank under R17's fall prevention interventions section. Review of R17's care plan last updated 1/1/13, did not identify the risk for falls nor any interventions to prevent further falls. During interview on 2/14/13, at 9:55 a.m., the director of nursing (DON) indicated when a resident fell the nursing assistant care sheet and care plans would be updated immediately. The DON was unable to identify if any interventions had been put into place after any of R17's falls and stated the fall reports would have that information. DON reviewed R17's care plan and nursing assistant care sheet and confirmed the lack of identification of fall risk status or any interventions to prevent future falls. Review of the facility's policy, "Care Plan Guide For Nursing" dated 05/04, revealed written individualized care plans would be developed and	2 560		

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2 560	Continued From page 3 revised for each resident for all staff to use. Review of the facility's policy, "Care Plans-Comprehensive" date 04/05, revealed each resident's comprehensive care plan would be designed to incorporate identified problem areas and incorporate risk factors associated with identified problems. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility owned multi-use glucometers (blood glucose meters used to check blood sugar levels) were sanitized between resident use to minimize the risk of transmission of potential blood borne infections for 1 of 2 observations, which affected 2 residents (R88 and R2).	21375		

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21375	Continued From page 4 Findings include: During observation on 2/11/13, at 4:55 p.m., licensed practical nurse (LPN)-A tested R88's blood sugar with a facility owned Assure Platinum glucometer. After the blood glucose reading was obtained, LPN-A returned to the medication cart, opened the top drawer, and put the glucometer into the drawer. LPN-A then pushed the medication cart to the next resident's (R2) room, who required a blood glucose check. At 5:01 p.m. LPN-A opened the top drawer on the medication cart and removed the same glucometer. LPN-A gathered her supplies and the glucometer, and proceeded into R2's room, and told R2 that she was going to check her blood glucose. At that time, LPN-A was stopped. During an interview on 2/11/13, at 5:03 p.m., LPN-A stated she did not know if the glucometers needed to be sanitized between residents. LPN-A walked to the nurse's station and looked for a policy book. The director of nursing (DON) was at the nurse's station. LPN-A asked the DON if glucometers needed to be cleaned between residents. The DON stated, "Yes." LPN-A stated, "I learned something new today." During an interview on 2/11/13, at 5:51 p.m., the DON stated infection control education, which included information about the importance of glucometers between residents, was provided to new employees upon hire and annually thereafter. During an interview on 2/11/13, at 6:40 p.m., LPN-A recalled that she received information about infection control when she started at the facility but did not remember if she received information about sanitizing glucometers between	21375		

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21375	Continued From page 5 residents. LPN-A stated she had, "Never worked anywhere that made you clean the glucometers." The facility's policy, "Recommended Infection-Control and Safe Injection Practices to Prevent Patient-To-Patient Transmission of Bloodborne Pathogens" dated 03/04, by Center for Disease Control and Prevention indicated, "If a glucometer that has been used for one patient must be used for another patient, the device must be cleaned and disinfected." The facility's policy, "Glucometer Cleaning Policy" dated 07/15/10, included, "It is the policy of this facility that glucometers that are shared between more than one resident are disinfected between each resident use." Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures related to sanitation of glucometer machines and ensure compliance with surveillance analysis. Time Period for Correction: Seven (7) days.	21375		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver:	21400		

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21400	Continued From page 6 - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure all residents' clinical records contained complete documentation of Tuberculin skin test (TST) screening (a skin test used to check for tuberculosis infection) for 2 of 7 residents (R1 and R17) reviewed for infection control. R1's second step TST injection was read on	21400		

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21400	Continued From page 7 08/31/12, and was recorded as checked on the treatment administration record, however no documentation noted whether the result was positive or negative nor millimeter (mm) measurement of induration was found in the chart. R17's second step TST was administered on 12/30/12, however no documentation noted to show the site had been checked or measured was found in the clinical chart. During an interview on 2/13/13, at 12:00 p.m., registered nurse (RN)-A confirmed there was no documentation in the clinical charts of R1 and R17 which indicated the TST tests in question were positive, negative or measured. RN-A indicated the nurse who had checked the testing site should have proceeded to the immunization record and completed the needed documentation and stated, "I see that we have some work to do with that." Review of the policy, "Tuberculosis Screening" revised 08/01, revealed all documentation pertaining to tuberculosis testing and the screening process will be filed in the employee's medical record. Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure newly admitted residents receive the tuberculin test as required by state rule and is documented correctly in the medical record. Revise the system as needed and educate staff on the system in place. Time Period for Correction: Twenty one (21) days	21400		

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21415	Continued From page 8	21415		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a	21415		

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21415	Continued From page 9 physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assure all employees were screened for the presence of tuberculosis (TB) prior to resident contact for 1 of 6 employees (LPN-A), whose records were reviewed. Findings include: Six new employee records were reviewed for compliance with tuberculosis screening. One new employee had not completed the screening prior to working with residents. New employee files were reviewed for staff hired after 10/11/12. One of the five randomly selected employee files revealed LPN-A was hired on 12/6/12, and received a tuberculin skin test (TST) that day, but there was no documentation indicating that it had been read for results within the forty-eight (48) to seventy-two (72) hour time period following the administration of the test. An attached printed message from an iphone indicated a previous coworker had read LPN-A's TST and, "It was negative." There was no date or specifics about the findings. The file also lacked evidence that a second TST had been given.	21415		

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21415	Continued From page 10 During interview on 2/14/13, at 1:15 p.m., human resources staff (HR)-A verified LPN-A started employment on 12/6/12, and had been working 64 hours, per pay period, on the night shift. HR-A verified the employee record lacked complete documentation in regards to the results of the TST given, and that the second TST had never been given. HR-A indicated LPN-A, "Would have to start over." HR-A indicated LPN-A had been given several reminders and had not followed through. Review of the "Orientation Program" checklist, revealed "Mantoux [tuberculin skin test]-1st step results must be read and negative." Review of the policy titled "Tuberculosis Screening" revised 08/01, revealed, "Upon employment" employees would receive a two step tuberculin skin test and the test would be read within 48 to 72 hours. Furthermore, a copy of all documentation pertaining to tuberculosis testing and the screening process, as well as reports of findings, would be filed in the employee's medical record. No further information was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor to assure TB screening procedures were developed and implemented to ensure staff were free of TB prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21415		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		

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21530	Continued From page 11 reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced	21530		

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21530	Continued From page 12 by: Based on interview and document review the facility failed to address the consulting pharmacist's recommendations for a taper of an antidepressant medication 1 of 10 residents (R2) reviewed for unnecessary medications. Findings include: Review of the current signed physician's orders for R2 included an order for Remeron (an antidepressant used to treat major depressive disorder) 7.5 milligrams (mg) orally at bedtime every day for depressive disorder. The consulting pharmacist conducted a review of R2's drug regimen on 12/27/12, and at that time noted "R2 was due for a GDR [gradual dose reduction] related to Remeron use." Registered nurse (RN)-A responded, "Done 11/27/12." On 1/22/13, the consulting pharmacist again reviewed R2's drug regimen and noted, "The only GDR reviews for Remeron I am able to find is from 9/20/12. Has one been done since and is not yet filed in chart? If not further documentation is needed from MD [medical doctor]-specifically why a decrease is contraindicated." RN-A again responded, "GDR done 11/27/12." A GDR for Remeron 7.5 mg was requested for the physician's evaluation on 8/2912. The physician's response on 9/20/12, was "No changes." During interview on 2/13/13, at 12:10 p.m., RN-A recalled starting a GDR form in the computer related to R2's use of Remeron on 11/27/12, but during review of the electronic chart and paper chart, RN-A was unable to find documentation to show the report had been given to the physician	21530		

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21530	Continued From page 13 or addressed at any time. RN-A indicated her process was to go back in the electronic chart and update the form after completion and the paper copy was to go in the paper chart under the medication tab so it would not get thinned out, but acknowledged that neither step had been completed in this case and was unable to provide any further information. During interview on 2/14/13, at 2:00 p.m., the consulting pharmacist verified the requests for R2's Remeron to be addressed regarding a GDR. The consulting pharmacist indicated the second review was requested appropriately as no documentation was found in the chart which indicated the GDR had been addressed correctly. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review the appropriateness of current medications for all residents, and refer any concerns to the attending physician and/or the consulting pharmacist. The quality assurance committe could randomly audit residents' drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing	21540		

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21540	Continued From page 14 home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility to identify ongoing clinical rationale for the continued use of an anti-depressant for 1 of 10 residents (R2) reviewed for unnecessary medications. Findings include: R2 had diagnoses which included depression. Review of the current signed physician's orders for R2 included an order for Remeron (an antidepressant used to treat major depressive disorder) 7.5 milligrams (mg) orally at bedtime every day for depressive disorder. The quarterly minimum data set (MDS) dated 7/2/12, identified R2 had a severe cognitive impairment, felt tired, felt bad about self and had thoughts of being better off dead or of hurting self in some way, several days during the assessment period.	21540		

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21540	Continued From page 15 The MDS care area assessment (CAA) dated 9/3/12, identified R2 had little interest in doing things and no changes in mood in past 90 days. The CAA further identified that R2 took an antidepressant for a diagnosis of depression. R2's care plan revised on 12/11/12, identified the use of an antidepressant for depression. The interventions listed included address minimum effective dose regimens with primary medical doctor per facility protocol and give medication as per physician orders for depression. A nursing psychotropic review note dated 1/29/2013, indicated R2 was taking Remeron for depression. The note further identified R2 had a history of weeping however no current episodes had been noted and would update the nurse practitioner that the medication seemed to be working well. The consulting pharmacist conducted a review of R2's drug regimen on 12/27/12, and at that time noted "R2 was due for a GDR [gradual dose reduction] related to Remeron use." Registered nurse (RN)-A responded, "Done 11/27/12." On 1/22/13, the consulting pharmacist again reviewed R2's drug regimen and noted, "The only GDR reviews for Remeron I am able to find is from 9/20/12. Has one been done since and is not yet filed in chart? If not further documentation is needed from MD [medical doctor]-specifically why a decrease is contraindicated." RN-A again responded, "GDR done 11/27/12." A GDR for Remeron 7.5 mg was requested for the physician's evaluation on 8/29/12. The physician's response on 9/20/12, was "No changes."	21540		

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21540	Continued From page 16 During interview on 2/13/13, at 12:10 p.m., RN-A recalled starting a GDR form in the computer related to R2's use of Remeron on 11/27/12, but during review of the electronic chart and paper chart, RN-A was unable to find documentation to show the report had been given to the physician or addressed at any time. RN-A indicated her process was to go back in the electronic chart and update the form after completion and the paper copy was to go in the paper chart under the medication tab so it would not get thinned out, but acknowledged that neither step had been completed in this case and was unable to provide any further information. A policy for gradual dose reductions was requested, however none which identified gradual dose reductions related to antidepressant use was provided. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and	21685		

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21685	Continued From page 17 well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and implement interventions to minimize falls for 1 of 3 residents (R17) reviewed for accidents. Furthermore, the facility failed to ensure that chemicals were properly stored in 1 of 2 tub rooms. This had the potential to affect three cognitively impaired residents who resided near the tub room. Findings include: R17 had sustained three falls since admission to the facility, the facility did not identify or implement any fall prevention interventions. R17 was admitted to the facility on 12/13/12, and had diagnoses which included but were not limited to dementia and muscle weakness. The admission minimum data set dated 12/26/12, identified R17 was moderately cognitively impaired and required extensive assistance from two staff for bed mobility and transferring. R17's care area assessment (CAA) dated 12/22/12, identified the potential for falls related to weakness, impaired balance during transitions, medication use and clinical diagnoses. The CAA indicated falls would be addressed in the care plan and the overall objective was to minimize risk. An incident report dated 1/1/13, noted, "Resident noted on floor upon entering room for routine	21685		

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rounds. Upon entering room, resident is noted to be on his left side on his shoulder and hip in the middle of the room." The report identified, "Only injury noted is a 1 cm [centimeter] in diameter scrape to the right knee with a scant amount of fresh dry blood." The response was, "Resident is resting with eyes closed at this time and has no complaint of pain. Nursing staff will continue to monitor this resident."

An incident report dated 1/21/13, noted, "Call light on resident hollering for help. Resident sitting on floor and wheelchair pedal. Resident stated that he slid out of his wheel chair. Did note some scratch marks on his left upper hip. Was assisted by 2 and transfer belt up into his wheelchair."

An incident report dated 2/2/13, noted, "Resident wanted to go to bed. Attempted to transfer self and slid out of w/c [wheelchair]. Found sitting on foot pedals of chair with back against the seat. No injuries found."

A fall review assessment completed on 1/1/13, indicated R17's Fall Care Plan had been reviewed and included needs and preferences which identified the interventions and approaches were effective in fall prevention.

The nursing assistant care sheet for the wing where R17 resided was blank under R17's fall prevention interventions section.

Review of R17's care plan last updated 1/1/13, did not identify the risk for falls nor any interventions to prevent further falls.

During interview on 2/14/12, at 9:05 a.m., nursing assistant (NA)-A stated R17 could be very difficult at times and would try to transfer alone. NA-A

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21685	Continued From page 19 further described R17 as non-compliant and indicated the staff needed to use reminders all the time to call for help. During interview on 2/14/13, at 9:55 a.m., director of nursing (DON) indicated when a resident suffered a fall the nursing assistant care sheet and care plans would be updated immediately. DON was unable to identify if any interventions had been put into place after any of R17's falls and stated the fall reports would have that information. DON reviewed R17's care plan and nursing assistant care sheet and confirmed the lack of identification of fall risk status or any interventions to prevent future falls. Review of the incident reports dated 1/1/13, 1/21/13 and 2/2/13 with administrator on 2/14/13 at 11:09 a.m., revealed that although the incident reports were reviewed in the interdisciplinary team (IDT) meetings, no interventions were put into place to prevent the resident from falling again. Administrator also confirmed no documentation was present which indicated the staff had discussed any risk versus benefits regarding falling with R17. A policy related to fall assessments and interventions was requested but none provided. During the environmental tour chemicals were observed in the 200 wing tub room which was unlocked and the door was wide open. On 2/13/13, at 1:07 p.m., the tub room on the 200 wing was observed to be unlocked and the door was wide open. A spray bottle of Hillyard Vindicator disinfectant was observed to sit on the sink. Also a plastic saline bottle with no label on it was on the sink. The liquid substance inside was	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING _____ B. WING _____	02/14/2013

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21685	Continued From page 20 a light red color. At 1:08 p.m. licensed practical nurse (LPN)-A verified the presence of the chemicals on the sink and indicated they should have been locked in the cupboard that was on the wall. LPN-A walked over to cupboard and opened it up, as it was also unlocked at the time. Inside the cupboard was another bottle of the Hillyard Vindicator disinfectant. LPN-A stated the cupboard was supposed to be locked but the keys used to lock the cupboard were not observed to hang on the side like usual. LPN-A then went down the hallway to NA-B and asked her if the tub room door was open so she could give a bath. NA-B stated no, it was open because she was used the Prolift machine which was stored in the tub room. LPN-A proceeded down the hall and entered the room where NA-B was. When LPN-A exited the room, she confirmed NA-B did not know what the light red liquid in the saline bottle was. On 2/13/13, at 1:20 p.m., the DON confirmed the tub room doors should always be closed and locked. DON was unable to identify the light red liquid in the saline bottle and was unable to explain how the chemicals were supposed to be stored in the tub rooms. The DON verified there were confused residents who resided on the 200 wing who were mobile and potentially could have wandered into the open tub room. Maintenance-A provided the material safety data sheet (MSDS) for the Hillyard Vindicator on 2/13/13, at 3:01 p.m. The MSDS indicated exposure to the Vindicator could cause irreversible eye damage and skin burns. The MSDS further indicated the product should be stored in its original container in areas inaccessible to children. Maintenance-A stated the chemicals in the bathroom should have been	21685		

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21685	Continued From page 21 stored in the locked cabinet on the wall. During interview on 2/13/13, at 3:30 p.m. the DON indicated she had not yet determined what type of liquid was in the saline bottle. On 2/13/13, at 3:35 p.m., human resources (HR) -A presented the facility's occupational safety and health administration (OSHA) hazardous communication information which was provided to all staff during initial employee training. Number two (e) on the document explains that product labels should contain information on how to shore and dispose of the product. HR-A stated that per the document, staffs were expected to check the manufacturer's label for storage information as guidance for how to handle chemicals in the facility. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and home-like manner. Ongoing maintenance, monitoring and record keeping to ensure that the environment, including resident rooms and equipment are maintained to eliminate offensive odors. Develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		