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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J0BU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00227

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

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

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

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

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

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

6. DATE OF SURVEY **03/14/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **137** (L18)
13.Total Certified Beds **137** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath Enforcement Specialist 03/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245272

March 15, 2016

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

Dear Ms. Barney:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 4, 2016 the above facility is certified for:

137 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

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

RE: Project Number S5272025

Dear Ms. Barney:

On February 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), hereby corrections were required.

On March 14, 2016, the Minnesota Departments of Health conducted a Post Certification Revisit (PCR) by review of your plan of correction and on March 14, 2016. the Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 4, 2016 and therefore remedies outlined in our letter to you dated February 9, 2016, 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.

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245272 Y1	A. Building B. Wing Y2	3/14/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0241	Correction	ID Prefix F0282	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix F0309	Correction	ID Prefix F0356	Correction	ID Prefix F0431	Correction
Reg. # 483.25	Completed	Reg. # 483.30(e)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	GL/mm	03/15/2016	15507	03/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245272	A. Building 01 - MAIN BUILDING 01 B. Wing	3/14/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0143	Correction Completed 02/19/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 03/15/2016	SIGNATURE OF SURVEYOR 37009	DATE 03/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/27/2016	☐ 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: J0BU

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

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

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

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

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

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

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

6. DATE OF SURVEY **01/28/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sandra Tatro, HFE NEII — 03/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24 5272

A standard survey was completed on January 28, 2016 to verify the facility was in compliance with Federal certification regulations. Deficiencies were cited with the most serious deficiencies cited at a scope and severity of E. The facility has been given an opportunity to correct before remedies would be imposed. In addition at the time of the standard survey, investigation of complaint numbers H5272061 and H5272062 were conducted and both were found unsubstantiated. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 forms (for both health and life safety code) along with the facility's plan of correction.

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 9, 2016

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

RE: Project Number S5272025, H5272061, H5272062

Dear Ms. Barney:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5272061 and H5272062 that were found to be unsubstantiated.

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 April 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. Complaints H5272061 and H5272062 were investigated at the time of the recertification survey and were found to be unsubstantiated.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		3/4/16

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

Electronically Signed | 02/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156		

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F 156	Continued From page 2 ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R148) reviewed for liability notices and beneficiary appeal rights. Findings include: R148's Admission Records dated 10/24/15, indicated the resident was admitted to the facility on 10/24/15, and discharged on 11/14/15. While at the facility, R148 was receiving physical and occupational therapy services. On 1/28/16, at approximately 2:00 p.m. the	F 156	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any	

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F 156	Continued From page 3 Notices of Medicare Non-Coverage were requested from the facility. R148's Notices of Medicare Non-Coverage form indicated that services would end on 11/13/15. However, the form was neither signed or dated, nor was there indication whether R148 ever received the notice. On 1/28/16, at 2:25 p.m. a clinical reimbursement specialist (CRS) was interviewed, and explained therapy staff usually provided notification when a resident's services were ending and she then notified the resident or family and had the form signed. The CRS confirmed that R148's form had not been signed and stated, "I'm not sure how this happened." The CRS was unsure whether R148 ever received the notice. The CRS explained, "We are supposed to notify the resident at least two days prior to their service ending," and R148's services ended on 11/13/15, and was discharged the following day. The facility's 9/13, Medicare Denial policy directed that, "The facility must notify the patient/responsible party at least two days prior to skilled care ending that Medicare benefits will end. The facility must issue an Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) (form CMS 10055) and completed copy of the Notice of Medicare Non-Coverage (NOMNC) (form CMS 10123)...Ensure beneficiary signs and dates."	F 156	conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. Resident 148 discharged from the facility on 11/14/15, therefore, it is not appropriate to issue a Notice of Medicare Non-Coverage now. Current residents, whose Medicare benefits will be ending, will be audited to ensure liability notices have been or will be provided to those residents. The Medicare A Denial policy will be	

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F 156	Continued From page 4	F 156	reviewed and revised as needed. Re-education will be provided to the Clinical Reimbursement Specialist and potential designee(s) on the revised policy and process. Random audits will be completed weekly by the Administrator or designee(s) for three months to ensure compliance. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Administrator is responsible for compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide 1 of 14 residents (R104) a dignified dining experience. Findings include: R104 was observed eating with her fingers without staff intervention on 1/25/16, at 5:50 p.m. R104 fed herself pasta with seafood cream sauce and green beans which was pureed (smooth,	F 241	Resident 104's care plan was updated to reflect the resident□s desire to eat with her fingers and plan to provide appropriate finger foods. Review and revise Meal Service policy, which includes dignified dining, and re-educate staff on revised policy. Will complete weekly random dining room	3/4/16

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F 241	Continued From page 5 pudding-like consistency) with her fingers while a nursing assistant (NA)-A was at the table assisting another resident to eat. R104 was licked the food from her fingers throughout the meal. At 6:18 p.m. R104 finished eating and after NA-A assisted her from the dining room, she explained R104 did not wear dentures and normally ate with her fingers. The following day at 12:20 p.m. R104 was totally assisted to eat. On 1/27/16, at 9:30 a.m. R104 fed herself breakfast which included ground sausage and scrambled eggs with her fingers, licking her fingers throughout the meal. During an interview on 1/27/16, at 12:56 p.m. with NA-B who consistently worked with R104, the NA stated the resident "loves to eat with her fingers" and generally did not allow staffs' assistance to eat. R104's quarterly Minimum Data Set (MDS) dated 11/5/15, identified the resident had dementia with severely impaired cognition. The resident required limited assistance with eating a mechanically altered (texture) diet. R104's current physician orders included "regular diet, dysphagia 3 [or DD3 for swallowing disorder] texture, thin consistency, refusing to wear dentures." R104's care plan dated 11/9/15, identified the potential for alteration in nutrition related to dementia an the need for a mechanically altered diet due to refusal to wear dentures; the resident required "some assist" with meals. Interventions directed staff to provide the physician prescribed diet with thin liquids, and to supervise the resident at mealtime due to her cognitive status. Staff was	F 241	audits to ensure dignified dining experience with current residents. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 241	Continued From page 6	F 241		

to open and pour liquids, cut up foods and spread condiments as needed. The care plan did not address the resident's desire to eat with her fingers, nor a plan for the provision of appropriate finger foods.

A registered nurse (RN)-A explained on 1/27/16, at approximately 3:00 p.m. R104's mood changed from day to day and occasionally she allowed staff assistance to eat. RN-A stated the resident did better with sandwiches and had difficulty grasping silverware with her fingers. RN-A reported that although the resident was prescribed a DD3 diet, she was able to eat sandwiches and "loves bread with jelly." RN-A said staff should have tried to offer R104 finger foods.

RN-B stated on 1/27/16, at 4:55 p.m. if R104 was able to manipulate silverware, she may have been be able to feed herself but if she was having difficulty, she could have been provided finger foods like bread with jelly or some toast. If she left the table she also could have been provided finger foods so she could walk around and still eat. RN-A reviewed the care plan and verified it did not include interventions related to the inability to utilize silverware. At approximately 5:00 p.m. RN-B provided an undated Modified Texture and Thickened Liquids guide. The guide indicated a DD3 diet "requires more chewing than DD2 diet, no hard or crusty foods, tailored more for oral control problems than swallowing problems. Meats may be chopped or ground and served with gravy or sauce. Rice should be pureed."

A related policy was requested on 1/27/16, but was not provided.

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F 282	Continued From page 7	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for dialysis access site care to minimize the risk of infection and clotting for 1 of 1 resident (R248) reviewed for dialysis. Findings include: R248's care plan initiated 9/16/15, identified the resident had a diagnosis of chronic renal failure and received dialysis three times weekly. The plan directed staff to check bruit and thrill daily, take vital signs daily and as needed, observe dialysis access site every shift and report negative findings/changes to the physician and dialysis center staff. If bleeding occurred at the access site, staff was directed to apply pressure until the bleeding stopped, and to notify the physician and dialysis center staff. The plan also directed staff to "remove dressing from access site six hours after dialysis, and wash access site daily with cares--do not scrub vigorously." On 1/28/16, at 11:32 p.m. RN-B stated the guidelines and care plan to manage the dialysis site were from R248's first admission to the facility. (The Admission Record dated 1/28/16, revealed and admission date of 11/16/15.) She	F 282	Resident 282's care plan was reviewed. Treatment sheet was updated to reflect appropriate monitoring. All current residents receiving dialysis will have their care plan audited to ensure compliance. The Individualized Care Plan and Care Cards policy was reviewed and revised. Re-education with the Inter-Disciplinary Team (IDT) members on Care Plan and Care Cards policy and compliance. Weekly random audits will be completed to ensure care plans are followed. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	3/4/16

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F 282	Continued From page 8 explained that when R248 returned from the hospital the physician orders had not been transcribed to the medication administration record (MAR) or the treatment administration record (TAR). "Honestly, if it is not on the MAR or TAR it probably is not being done." The facility's 12/13, Policy/Procedure Series Subject Dialysis Resident--Care directed staff to "assess patient complication post dialysis therapy to assess internal accesses (fistulas and grafts): for infection--warmth, pain, redness, swelling, discharge, tenderness (assess daily), dressing--remove Band-Aids or gauze 4 hours after discharge from dialysis, clotted access--notify the dialysis unit or the nephrologist, hematoma--apply ice to the site for 24 hours then apply warm packs, access bleeding post dialysis--apply direct pressure to site for 10 minutes." The facility's 12/13, Individualized Care Plan and Care Cards policy indicated "a resident profile will be maintained accurate with information identified on the Resident Care Plan. The Profile should be reviewed at each quarterly update of care plan to assure all information is timely and accurate." In an interview with the director of nursing on 1/28/16, at 1:30 p.m. it was stated the expectation was for the care plan to be up-to-date and followed by staff.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		3/4/16

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F 309	Continued From page 9 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure services were provided to a dialysis access site to minimize the risk of infection and clotting for 1 of 1 resident (R248) reviewed for dialysis. Findings include: R248 was observed on 1/27/16, at approximately 8:30 a.m. in his room. There was no dressing to dialysis access site observed on the resident's left upper arm. A licensed practical nurse (LPN)-B stated R248 went to dialysis on Monday, Wednesday and Friday each week. LPN-B stated she did not manage his dialysis access site or dressing and was unaware of what was actually related to R248's dressing after 3:00 p.m. as she was off duty. On 1/28/16, at 8:37 a.m. R248 was again lying in bed. No dressing was observed on his left upper extremity access site. When asked who had removed the dressing he stated he had because it was itching. He further explained he always removed the dressing and denied nurses in the facility had ever managed the site or removed the dressing. R248's care plan initiated 9/16/15, revealed the resident had a diagnosis of chronic renal failure and received dialysis three times weekly. The	F 309	Resident 248's care plan was reviewed. Treatment sheet was updated to reflect appropriate monitoring. Review and revise Individualized Care Plan and Care Cards policy. Re-education with the Inter-Disciplinary Team (IDT) members and Licensed Nursing on Individualized Care Plan and Care Cards policy and revising, updating, and following care plans. Review care of dialysis residents with IDT and Licensed Nursing. Weekly random audits will be completed to ensure compliance with following care plan. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 309	Continued From page 10	F 309		

plan directed staff to "check bruit and thrill daily [to ensure proper function of the site], take vital signs daily and as needed, observe dialysis access site every shift and report negative findings/changes to the physician and dialysis center staff. If bleeding occurred at the access site, staff was directed to apply pressure until the bleeding stopped, and to notify the physician and dialysis center staff...remove dressing from access site six hours after dialysis, and wash access site daily with cares--do not scrub vigorously."

Although the Minimum Data Set dated 1/11/16, identified R248 to had moderate cognitive impairment, it also indicated he had the ability to understand others, had clear comprehension, clear speech and the ability to express ideas and wants.

Review of the 1/16, TAR revealed R248 was receiving Coumadin. The TAR directed staff to: "observe fistula/graft for patency: Feel for thrill, listen with stethoscope for bruit. Notify MD and dialysis for absence of sound. Write a progress note for absence of sound and notify [nurse practitioner/physician] (nursing order) in the morning for dialysis monitoring. Order date 1/28/16."

The 11/15, 12/15 and through 1/28/16 TAR lacked direction to monitor or document the condition of the dialysis access site for R248. However the TAR from this time period did direct staff to remove the bandage every night on Monday, Wednesday and Friday because R248 had some skin breakdown from the tape.

An interview was conducted with a registered

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nurse (RN)-B on 1/28/16, at 8:44 a.m. R248 reportedly had dialysis three days weekly. The facility did not have an emergency plan or supplies to manage residents receiving dialysis should he have been unable to receive dialysis. She further explained that although he rarely missed dialysis, there was not an emergency plan in place if should R248 be unable or restricted from getting to the dialysis facility. RN-B said there was a physician's order directing nursing staff to remove the dressing "at night," however, it was not noted on the treatment administration record (TAR). I was an expectation of RN-B that staff "re-wrap it if it is bleeding and to call the doctor if it is infected." RN-B also explained R248 was prescribed the blood thinner, Coumadin and heart medication, so close monitoring was required because the resident had "very thin blood," however, because there was no direction on the TAR or medication administration record (MAR) and she was unsure if it was being regularly documented.

Later at 11:02 a.m. LPN-B stated R248's dressing was always removed by morning and and LPN-B therefore, did not document monitoring of bruit and thrill or clotting at the dialysis site.

On 1/28/16, at 11:10 a.m. the dialysis nurse (RN-C) from DaVita Dialysis stated R248 was originally given guidelines to manage the access site for clotting and infection and when he was placed on dialysis services. However, when he admitted to the long term care facility, the papers would not have followed the resident, and the facility had not requested verbal or written instructions related to managing the dialysis access site for R248. She stated she expected the facility would remove the dressing the

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morning following dialysis, and monitor the site at least daily for clotting and clotting, and infection.

On 1/28/16, at 11:32 p.m. RN-B stated the guidelines and care plan to manage the dialysis site were from R248's first admission to the facility. (The Admission Record dated 1/28/16, revealed and admission date of 11/16/15.) She explained that when R248 returned from the hospital the physician orders had not been transcribed to the medication administration record (MAR) or the treatment administration record (TAR). "Honestly, if it is not on the MAR or TAR it probably is not being done."

An interview on 1/28/16, at 1:39 p.m. the director of nursing revealed that when R248 returned from the hospital his orders were not transcribed to the MAR. "The problem is that unit does not get a lot of dialysis residents and it was missed. He [R248] has a lot of orders. There should have been two checks. It was missed. I would expect this to be followed through."

The facility's 12/13, Policy/Procedure Series Subject Dialysis Resident--Care directed staff to "assess patient complication post dialysis therapy to assess internal accesses (fistulas and grafts): for infection--warmth, pain, redness, swelling, discharge, tenderness (assess daily), dressing--remove Band-Aids or gauze 4 hours after discharge from dialysis, clotted access--notify the dialysis unit or the nephrologist, hematoma--apply ice to the site for 24 hours then apply warm packs, access bleeding post dialysis--apply direct pressure to site for 10 minutes."

The undated DaVita Dialysis Guidelines directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 staff to: "Check dressing site daily...Monitor, document and report prn any s/sx [as needed signs and symptoms] of infection to access site: redness, swelling, warmth or drainage."	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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F 356	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the required nurse staffing information to reflect actual hours worked for licensed staff on all shifts as required. This practice had the potential to affect all 130 residents in the facility and visitors. Findings include: During initial tour of the facility, on 1/25/16, at approximately 11:45 p.m. the staffs' Projected Nurse Staffing Information dated 1/25/16, was observed on the wall adjacent to the desk near the main entrance. 1) For the 6:30 a.m. to 3:00 p.m. were: five registered nurses (RNs), seven licensed practical nurses (LPNs), and 16 nursing assistants (NAs) from 6:00 a.m. to 2:00 p.m. 2) For 2:30 p.m. through 11:00 p.m. were: six RNs, five LPNs, and two NAs from 3:00 p.m. to 11:00 p.m. and 14 NAs from 2:00 p.m. to 10:00 p.m. 3) For 10:30 p.m. through 7:00 a.m. were: two RNs, three LPNs, and five NAs from 10:00 p.m. to 6:00 a.m. and 2 NAs from 11:00 p.m. to 7:00 a.m. The total projected nursing hours for 1/25/16, was: 104 RN hours, 120 LPN hours and 292.5 NA hours. The posted census was 129 residents for long and short term care. A three-ringed binder labeled Actual Nurse Staffing Information was on a shelf below the	F 356	Posted actual hours were available in a binder just below the posted projected daily hours. Therefore, this did not directly impact any residents or visitors. We reviewed and revised the Nursing Staffing Hours policy and provided re-education to the staff responsible for posting hours. Weekly random audits will be completed to ensure compliance. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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F 356	Continued From page 15 posted staffing hours labeled Projected Nursing Staffing Information. On 1/26/16, 8:15 a.m. the Projected Staff Nursing information was again posted on the wall adjacent to the desk near the main entrance. The three-ringed binder Actual Nurse Staffing Information was below the posting on a shelf. Included in the binder was the Actual Staff Posting Information dated 1/25/16. The nursing staff actual hours for 1/25/16 were as follows: 1) For 6:30 a.m. through 3:00 p.m. were four RNs, six LPNs, two trained medication aides (TMAs and 13 NAs from 6:00 a.m. to 2:00 p.m. 2) For 2:30 p.m. through 11:00 p.m. were six RNs, three LPNs, two TMAs and 12 NAs from 2:00 p.m. to 10.:00 p.m. and 1 NAs from 3:00 p.m. to 11:03 p.m. 3) For 10:30 p.m. to 7:00 a.m. were three RNs, one LPN, one TMA, five NAs from 10:00 p.m. to 6:00 a.m. and two NAs from 11:00 p.m. to 7:00 a.m. The total actual nursing hours for 1/25/16, was 109 RN hours, 83.75 LPN hours, 39.25 TMA hours and 261.25 NA. The posted census was 130 residents for long and short term care. This practice was also observed 1/26/16, 1/27/16 and 1/28/16. During an interview on 1/27/16, at 10:27 a.m. the staffing coordinator explained he completed The Projected Staff Nursing Information sheet for the	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/28/2016

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F 356	Continued From page 16 following day and gave it to the receptionist before he left for the day. The following day the receptionist posted the projected hours at approximately 8:00 a.m. He did not update or verify the posting during the day but was instructed to put The Actual Staff Nursing Information sheet in a binder at the reception desk near the front entrance. The facility's 8/20/14, Policy/Procedure Series Nursing Staffing Hours directed "staff must post the the total number of actual hours worked for: registered nurses, licensed practical nurses and certified nursing assistants." An interview with the director of nursing (DON) on 1/28/16, at 1:30 p.m. revealed the daily staff posting was a projection of hours of work for licensed nursing staff and NAs. Actual hours worked by nursing staff was not posted, but instead was placed in a book near the reception area. The DON further explained the staff information was not updated with changes.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		3/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 17 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired tuberculin solution was not available for use for 1 of 4 medication storage areas reviewed. This has the potential to affect 15 residents residing on the unit. Findings include: During observation of the medication storage area on 1/27/16, at 10:59 a.m. an opened box which contained a multi-dose bottle of tuberculin purified derivative, (sterile aqueous solution to tuberculosis testing) was observed stored in the refrigerator. The date on the box indicated the	F 431	We could not identify any residents who were affected from this as there were no new admissions to that unit. All refrigerators were checked for expired medications to ensure no other residents could be impacted. We reviewed and revised the Administration Procedures for all Medications Long-Term Care policy and provided re-education to the nursing staff. Weekly random audits will be completed to ensure compliance.	

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	245272	A. BUILDING _____ B. WING _____	01/28/2016

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F 431	Continued From page 18 medication was opened 11/18/15. The bottle of tuberculin indicated approximately half of the medication was used (approximately five doses administered). In an interview with a licensed practical nurse (LPN)-A on 1/27/16, at 10:59 a.m. she stated she was unaware how long tuberculin solution could be used once opened. During interview with the registered nurse (RN)-B on 1/27/16, at 11:03 a.m. she also states he was unaware how long tuberculin solutions would be considered viable once opened, and would need to check the facility's policy. The facility's undated medication listing "These Mediations Need Expiration Stickers" and included Tubersol Apisol was to be stored in the refrigerator and "expired after 30 days."	F 431	A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/27/2016**

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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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 27, 2016. At the time of this survey, Martin Luther Care Center, 1984 Building, 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/27/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us, Angela.Kappenman@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. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (222) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 124 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/27/2016**

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K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the room used for storage and transfill of liquid oxygen does not comply with NFPA 99. This deficient practice could affect 22 residents. Findings include: On facility tour between 9:00 AM and 12:30 PM on 01/27/2016, observation revealed that there was vinyl tile covering on the floor of the second level oxygen transfill room that is not in compliance with NFPA 99 section 8.6.2.5.2. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 143	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by	2/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/27/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 143	Continued From page 3	K 143	the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs The vinyl tile covering on the floor of the second level oxygen transfill room was removed on 2/18/2016 and concrete is now the flooring in the room which is in compliance with NFPA 99 section 8.6.2.5.2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **03 - NEW RESIDENCE** B. WING _____	**01/27/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 27, 2016. At the time of this survey, Martin Luther Manor, 2010 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (222) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 124 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **03 - NEW RESIDENCE** B. WING _____	**01/27/2016**

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	245272	A. BUILDING **04 - ADMINISTRATION AND ASSEMBLY** B. WING _____	**01/27/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 27, 2016. At the time of this survey, Martin Luther Care Center, 2011 Building, 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 18 New Health Care. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (222) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 124 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **04 - ADMINISTRATION AND ASSEMBLY** B. WING _____	**01/27/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
February 9, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5272025
Dear Ms. Barney:

The above facility was surveyed on January 25, 2016 through January 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5272061 and H5272062 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gayle Lantto, at 651-201-3794.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00227	A. BUILDING: _____ B. WING _____	01/28/2016

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 25, 26, 27, and 28, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. Complaints H5272061 and H5272062 were investigated at the time of the licensing survey and were found unsubstantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for dialysis access site care to minimize the risk of infection and clotting for 1 of 1 resident (R248) reviewed for dialysis. Findings include: R248's care plan initiated 9/16/15, identified the resident had a diagnosis of chronic renal failure and received dialysis three times weekly. The plan directed staff to check bruit and thrill daily, take vital signs daily and as needed, observe dialysis access site every shift and report negative findings/changes to the physician and dialysis center staff. If bleeding occurred at the access site, staff was directed to apply pressure until the bleeding stopped, and to notify the physician and dialysis center staff. The plan also	2 565	We have reviewed these orders.	3/4/16

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2 565	Continued From page 3 directed staff to "remove dressing from access site six hours after dialysis, and wash access site daily with cares--do not scrub vigorously." On 1/28/16, at 11:32 p.m. RN-B stated the guidelines and care plan to manage the dialysis site were from R248's first admission to the facility. (The Admission Record dated 1/28/16, revealed and admission date of 11/16/15.) She explained that when R248 returned from the hospital the physician orders had not been transcribed to the medication administration record (MAR) or the treatment administration record (TAR). "Honestly, if it is not on the MAR or TAR it probably is not being done." The facility's 12/13, Policy/Procedure Series Subject Dialysis Resident--Care directed staff to "assess patient complication post dialysis therapy to assess internal accesses (fistulas and grafts): for infection--warmth, pain, redness, swelling, discharge, tenderness (assess daily), dressing--remove Band-Aids or gauze 4 hours after discharge from dialysis, clotted access--notify the dialysis unit or the nephrologist, hematoma--apply ice to the site for 24 hours then apply warm packs, access bleeding post dialysis--apply direct pressure to site for 10 minutes." The facility's 12/13, Individualized Care Plan and Care Cards policy indicated "a resident profile will be maintained accurate with information identified on the Resident Care Plan. The Profile should be reviewed at each quarterly update of care plan to assure all information is timely and accurate." In an interview with the director of nursing on 1/28/16, at 1:30 p.m. it was stated the expectation was for the care plan to be up-to-date and	2 565		

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2 565	Continued From page 4 followed by staff. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures for revision of the care plan, provide education to nursing staff pertaining to the follow through of the care plan, then develop and implement an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure services were provided to a dialysis access site to minimize the risk of infection and clotting for 1 of 1 resident (R248) reviewed for dialysis. Findings include:	2 830	We have reviewed these orders.	3/4/16

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2 830	Continued From page 5 R248 was observed on 1/27/16, at approximately 8:30 a.m. in his room. There was no dressing to dialysis access site observed on the resident's left upper arm. A licensed practical nurse (LPN)-B stated R248 went to dialysis on Monday, Wednesday and Friday each week. LPN-B stated she did not manage his dialysis access site or dressing and was unaware of what was actually related to R248's dressing after 3:00 p.m. as she was off duty. On 1/28/16, at 8:37 a.m. R248 was again lying in bed. No dressing was observed on his left upper extremity access site. When asked who had removed the dressing he stated he had because it was itching. He further explained he always removed the dressing and denied nurses in the facility had ever managed the site or removed the dressing. R248's care plan initiated 9/16/15, revealed the resident had a diagnosis of chronic renal failure and received dialysis three times weekly. The plan directed staff to "check bruit and thrill daily [to ensure proper function of the site], take vital signs daily and as needed, observe dialysis access site every shift and report negative findings/changes to the physician and dialysis center staff. If bleeding occurred at the access site, staff was directed to apply pressure until the bleeding stopped, and to notify the physician and dialysis center staff...remove dressing from access site six hours after dialysis, and wash access site daily with cares--do not scrub vigorously." Although the Minimum Data Set dated 1/11/16, identified R248 to had moderate cognitive impairment, it also indicated he had the ability to	2 830		

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2 830	Continued From page 6 understand others, had clear comprehension, clear speech and the ability to express ideas and wants. Review of the 1/16, TAR revealed R248 was receiving Coumadin. The TAR directed staff to: "observe fistula/graft for patency: Feel for thrill, listen with stethoscope for bruit. Notify MD and dialysis for absence of sound. Write a progress note for absence of sound and notify [nurse practitioner/physician] (nursing order) in the morning for dialysis monitoring. Order date 1/28/16." The 11/15, 12/15 and through 1/28/16 TAR lacked direction to monitor or document the condition of the dialysis access site for R248. However the TAR from this time period did direct staff to remove the bandage every night on Monday, Wednesday and Friday because R248 had some skin breakdown from the tape. An interview was conducted with a registered nurse (RN)-B on 1/28/16, at 8:44 a.m. R248 reportedly had dialysis three days weekly. The facility did not have an emergency plan or supplies to manage residents receiving dialysis should he have been unable to receive dialysis. She further explained that although he rarely missed dialysis, there was not an emergency plan in place if should R248 be unable or restricted from getting to the dialysis facility. RN-B said there was a physician's order directing nursing staff to remove the dressing "at night," however, it was not noted on the treatment administration record (TAR). I was an expectation of RN-B that staff "re-wrap it if it is bleeding and to call the doctor if it is infected." RN-B also explained R248 was prescribed the blood thinner, Coumadin and heart medication, so close monitoring was	2 830		

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2 830	Continued From page 7	2 830		

required because the resident had "very thin blood," however, because there was no direction on the TAR or medication administration record (MAR) and she was unsure if it was being regularly documented.

Later at 11:02 a.m. LPN-B stated R248's dressing was always removed by morning and and LPN-B therefore, did not document monitoring of bruit and thrill or clotting at the dialysis site.

On 1/28/16, at 11:10 a.m. the dialysis nurse (RN-C) from DaVita Dialysis stated R248 was originally given guidelines to manage the access site for clotting and infection and when he was placed on dialysis services. However, when he admitted to the long term care facility, the papers would not have followed the resident, and the facility had not requested verbal or written instructions related to managing the dialysis access site for R248. She stated she expected the facility would remove the dressing the morning following dialysis, and monitor the site at least daily for clotting and clotting, and infection.

On 1/28/16, at 11:32 p.m. RN-B stated the guidelines and care plan to manage the dialysis site were from R248's first admission to the facility. (The Admission Record dated 1/28/16, revealed and admission date of 11/16/15.) She explained that when R248 returned from the hospital the physician orders had not been transcribed to the medication administration record (MAR) or the treatment administration record (TAR). "Honestly, if it is not on the MAR or TAR it probably is not being done."

An interview on 1/28/16, at 1:39 p.m. the director of nursing revealed that when R248 returned from the hospital his orders were not transcribed to the

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2 830	Continued From page 8 MAR. "The problem is that unit does not get a lot of dialysis residents and it was missed. He [R248] has a lot of orders. There should have been two checks. It was missed. I would expect this to be followed through." The facility's 12/13, Policy/Procedure Series Subject Dialysis Resident--Care directed staff to "assess patient complication post dialysis therapy to assess internal accesses (fistulas and grafts): for infection--warmth, pain, redness, swelling, discharge, tenderness (assess daily), dressing--remove Band-Aids or gauze 4 hours after discharge from dialysis, clotted access--notify the dialysis unit or the nephrologist, hematoma--apply ice to the site for 24 hours then apply warm packs, access bleeding post dialysis--apply direct pressure to site for 10 minutes." The undated DaVita Dialysis Guidelines directed staff to: "Check dressing site daily...Monitor, document and report prn any s/sx [as needed signs and symptoms] of infection to access site: redness, swelling, warmth or drainage." SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures, provide staff education pertaining to the revision of care plan with any change of condition or physician recommendation, and develop and/or implement an auditing system to ensure on-going compliance. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21426	Continued From page 9	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not ensure State guidelines to ensure Employee Tuberculosis (TB) Screening, Tuberculin Skin Test (TST) and medical evaluations for 3 of 5 employees (E1, E2, E3) was completed prior to employment in the facility. In addition 3 of 5 residents (R5, R117, R248) did not receive TB screening or TST testing in a timely manner. Findings include:	21426	We have reviewed these orders.	3/4/16

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21426	Continued From page 10 A review of employee files revealed E-1 had a start date of 12/14/15. A TB symptom screen and the first-step TST was done on 12/14/15. A second TST, a blood test or a chest x-ray was not completed. E-2 had a start date, symptom screen and first step TST on 10/19/15. A second TST, a blood test or a chest x-ray was not completed. E-3 had a start date of 11/23/15. A TB symptom screen was also done on her date-of-hire. The first-step TST was done on 12/14/15. A second TST, a blood test or a chest x-ray was not completed. E-4's start date was 11/16/15. A TB symptom screen was done 11/16/15. Although the facility did a second step TST on 11/16/15, the first-step TST from prior employment was completed 5/11/15. A review of resident immunization record revealed R5 was admitted 1/14/16. A TB symptom screen was done 11/3/15 and TST was given on 11/4/15. No other indication of TB testing was found in her record. R117 and R248 were admitted on 11/16/15 and also completed a TB screen on this day. No TB testing was found in either resident record. The Ebenezer Policy/Procedure Series Tuberculosis Screening- Resident, effective date 1/15, states: It is the policy to provide identification of past exposure or active Tuberculosis for each resident admission and to establish a TST baseline for future reference. Upon admission all residents will be assessed for symptoms of and risk factors for tuberculosis AND have a 2-step TST unless otherwise indicated The Ebenezer Policy/Procedure Series Tuberculosis Screening- Employee, effective date 7/15, states: It is the policy to follow State	21426		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 11 requirements regarding Tuberculosis screening of all employees with past exposure to or active tuberculosis at time of hire, and to establish a TST baseline for future reference. All employees will be screened for symptoms of and risk factors tuberculosis AND have a 2-step TST unless otherwise indicated. First step TST to be done upon hire. Second -step TST will be done 1-3 weeks after first TST. An interview with the director of nursing on (DON) 1/27/16, at approximately 2:15 p.m., revealed the infection control nurse responsible for tracking tuberculosis screening and testing for both staff and residents had quit within the last several months. She verified staff and residents TST were not completed as per their policy. The DON explained that she and another staff member were "trying to catch-up". She stated all employees and residents were to have a TB screening and TST series completed upon admission or hire unless a chest x-ray had been done. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service the staff responsible for completing and monitoring the TB program to ensure it is consistent with current TB requirements. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		3/4/16

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	00227	A. BUILDING: _____ B. WING _____	01/28/2016

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21620	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired tuberculin solution was not available for use for 1 of 4 medication storage areas reviewed. This has the potential to affect 15 residents residing on the unit. Findings include: During observation of the medication storage area on 1/27/16, at 10:59 a.m. an opened box which contained a multi-dose bottle of tuberculin purified derivative, (sterile aqueous solution to tuberculosis testing) was observed stored in the refrigerator. The date on the box indicated the medication was opened 11/18/15. The bottle of tuberculin indicated approximately half of the medication was used (approximately five doses administered). In an interview with a licensed practical nurse (LPN)-A on 1/27/16, at 10:59 a.m. she stated she was unaware how long tuberculin solution could be used once opened. During interview with the registered nurse (RN)-B on 1/27/16, at 11:03 a.m. she also states he was unaware how long tuberculin solutions would be considered viable once opened, and would need to check the facility's policy. The facility's undated medication listing "These Mediations Need Expiration Stickers" and included Tubersol Apisol was to be stored in the refrigerator and "expired after 30 days." SUGGESTED METHOD OF CORRECTION:	21620	We have reviewed these orders.	

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21620	Continued From page 13 The pharmacist and/or director of nursing could in-service all staff responsible for medications the need to secure medications and follow disposal of medications according to the facility policy/procedure. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21620		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request	21800		3/4/16

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21800	Continued From page 14 to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide liability notices for 1 of 3 residents (R148) reviewed for liability notices and beneficiary appeal rights. Findings include: R148's Admission Records dated 10/24/15, indicated the resident was admitted to the facility on 10/24/15, and discharged on 11/14/15. While at the facility, R148 was receiving physical and occupational therapy services. On 1/28/16, at approximately 2:00 p.m. the Notices of Medicare Non-Coverage were requested from the facility. R148's Notices of Medicare Non-Coverage form indicated that services would end on 11/13/15. However, the form was neither signed or dated, nor was there indication whether R148 ever received the notice. On 1/28/16, at 2:25 p.m. a clinical reimbursement specialist (CRS) was interviewed, and explained therapy staff usually provided notification when a resident's services were ending and she then notified the resident or family and had the form signed. The CRS confirmed that R148's form had not been signed and stated, "I'm not sure how this happened." The CRS was unsure whether R148 ever received the notice. The CRS explained, "We are supposed to notify the	21800	We have reviewed these orders.	

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21800	Continued From page 15 resident at least two days prior to their service ending," and R148's services ended on 11/13/15, and was discharged the following day. The facility's 9/13, Medicare Denial policy directed that, "The facility must notify the patient/responsible party at least two days prior to skilled care ending that Medicare benefits will end. The facility must issue an Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) (form CMS 10055) and completed copy of the Notice of Medicare Non-Coverage (NOMNC) (form CMS 10123)...Ensure beneficiary signs and dates." SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures, provide staff re-education regarding liability notices and beneficiary appeal rights, and develop and/or implement an auditing system to ensure on-going compliance. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by:	21805		3/4/16

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21805	Continued From page 16 Based on observation, interview, and document review, the facility failed to provide 1 of 14 residents (R104) a dignified dining experience. Findings include: R104 was observed eating with her fingers without staff intervention on 1/25/16, at 5:50 p.m. R104 fed herself pasta with seafood cream sauce and green beans which was pureed (smooth, pudding-like consistency) with her fingers while a nursing assistant (NA)-A was at the table assisting another resident to eat. R104 was licked the food from her fingers throughout the meal. At 6:18 p.m. R104 finished eating and after NA-A assisted her from the dining room, she explained R104 did not wear dentures and normally ate with her fingers. The following day at 12:20 p.m. R104 was totally assisted to eat. On 1/27/16, at 9:30 a.m. R104 fed herself breakfast which included ground sausage and scrambled eggs with her fingers, licking her fingers throughout the meal. During an interview on 1/27/16, at 12:56 p.m. with NA-B who consistently worked with R104, the NA stated the resident "loves to eat with her fingers" and generally did not allow staffs' assistance to eat. R104's quarterly Minimum Data Set (MDS) dated 11/5/15, identified the resident had dementia with severely impaired cognition. The resident required limited assistance with eating a mechanically altered (texture) diet. R104's current physician orders included "regular diet, dysphagia 3 [or DD3 for swallowing disorder] texture, thin consistency, refusing to wear dentures."	21805	We have reviewed these orders.	

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21805	Continued From page 17 R104's care plan dated 11/9/15, identified the potential for alteration in nutrition related to dementia an the need for a mechanically altered diet due to refusal to wear dentures; the resident required "some assist" with meals. Interventions directed staff to provide the physician prescribed diet with thin liquids, and to supervise the resident at mealtime due to her cognitive status. Staff was to open and pour liquids, cut up foods and spread condiments as needed. The care plan did not address the resident's desire to eat with her fingers, nor a plan for the provision of appropriate finger foods. A registered nurse (RN)-A explained on 1/27/16, at approximately 3:00 p.m. R104's mood changed from day to day and occasionally she allowed staff assistance to eat. RN-A stated the resident did better with sandwiches and had difficulty grasping silverware with her fingers. RN-A reported that although the resident was prescribed a DD3 diet, she was able to eat sandwiches and "loves bread with jelly." RN-A said staff should have tried to offer R104 finger foods. RN-B stated on 1/27/16, at 4:55 p.m. if R104 was able to manipulate silverware, she may have been be able to feed herself but if she was having difficulty, she could have been provided finger foods like bread with jelly or some toast. If she left the table she also could have been provided finger foods so she could walk around and still eat. RN-A reviewed the care plan and verified it did not include interventions related to the inability to utilize silverware. At approximately 5:00 p.m. RN-B provided an undated Modified Texture and Thickened Liquids guide. The guide indicated a DD3 diet "requires more chewing than DD2 diet,	21805		

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21805	Continued From page 18 no hard or crusty foods, tailored more for oral control problems than swallowing problems. Meats may be chopped or ground and served with gravy or sauce. Rice should be pureed." A related policy was requested on 1/27/16, but was not provided. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures, provide staff education pertaining to dignity in the dining rooms, and develop and/or implement an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		