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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JUDQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/26/2016** (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)
07/27

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	109			
(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 :
Gayle Lantto, Unit Supervisor 09/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/29/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245067

October 6, 2016

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

Dear Mr. Gubbels:

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

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

Effective August 26, 2016 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 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
September 9, 2016

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

RE: Project Number S5067026

Dear Mr. Gubbels:

On July 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 5, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 26, 2016 and therefore remedies outlined in our letter to you dated July 22, 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
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
245067 Y1	A. Building B. Wing Y2	8/26/2016 Y3

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

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 F0242	Correction	ID Prefix F0272	Correction	ID Prefix F0309	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.25	Completed
LSC	08/26/2016	LSC	08/26/2016	LSC	08/26/2016
ID Prefix F0334	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/26/2016	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	
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
[X]	GL/mm	09/09/2016	15507	08/26/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

[ ] 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245067 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/5/2016 Y3

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

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	07/15/2016	LSC K0027	07/15/2016	LSC K0034	07/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0066	07/19/2016	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	
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
[x]	TL/mm	09/09/2016	37008	08/05/2016`
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

[ ] 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: JUDQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2016** (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)
07/27

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
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
	109			
(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 :
Douglas Stevens, HFE NEII 08/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5067

At the time of the July 14, 2016 recertification survey the facility was not in substantial compliance with Federal participation requirements. In addition, at the time of the survey an investigation of complaiint number H5067014 was conducted and found to be unsubstantiated. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0618

July 22, 2016

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

RE: Project Number H5067014

Dear Mr. Gubbels:

On July 14, 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. In addition, at the time of the July 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5067014.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number that was 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us
Phone: (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 August 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 23, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 14, 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 January 14, 2017 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	07/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5067014 was investigated at the time of the recertification survey, and was found unsubstantiated.	F 000		
F 242 SS=D	483.15(b). SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system to identify resident preferences for waking for 1 of 3 residents (R170) reviewed for choices. Findings include: R170 stated in an interview on 712/16, at 9:20	F 242	RECEIVED AUG 03 2016 BY: _____ POC accepted 8/3/16 F242 Immediate corrective action: A Grievance report was completed on behalf of resident R170 for not being given a choice when he gets up in the morning, with the resolution reviewed by the ID Team.	

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

Joe Dubbels — ADMINISTRATOR — 8/3/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	07/14/2016

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F 242	Continued From page 1 a.m. he was not given a choice as to when he gets up in the morning. He said staff came into his room at 4:00 a.m. to dress him, and then assisted him back to bed until it was time for breakfast. His preference when he was living at home was to get up at approximately 7:00 a.m. and then he went to bed about 10:00 or 11:00 p.m. He stated he did not like getting dressed and being put back to bed. R170 said it did not happen every night, but did happen a "couple of times a week or so." The following day on 7/13/16, at 7:05 a.m. R170 was observed in bed with his eyes closed, but was not dressed for the day. At 7:50 a.m. the resident was up in his wheelchair and was dressed. A nursing assistant (NA)-A said she had just assisted the resident out of bed. Later at 1:06 p.m. NA-A explained she usually assisted R170 to get up in the morning. She walked him to the bathroom, washed his face and under arms, and performed peri care. The resident was able to brush his own teeth. NA-A said the time she assisted the resident out of bed varied, depending on when he needed to use the toilet. She said staff generally assisted R170 up between 7:00 and 7:30 a.m. but the night shift staff did occasionally get him dressed for the day. NA-A was unsure the rationale. She said it varied depending who was working, and when the male NA worked, he generally got him dressed. NA-A said R170 had not informed her he did not want to get up on the night shift. During an interview with a trained medication aide (TMA)-A on 7/13/16, at 8:34 a.m. she stated the resident generally got up at 7:00 or 7:15 a.m. TMA-A said R170 sometimes complained about getting up, and staff then left him in bed until he	F 242	Action as it applies to others: All current residents able to be interviewed will be asked their preference regarding when to get up in the morning. Personal preferences regarding resident's choice for when to get up in the morning will be care planned accordingly. Staff will be re-educated regarding honoring residents' choices by 8/26/2016. **Date of completion:** 8/26/2016. **Recurrence will be prevented by:** Random weekly resident interviews will be completed to ensure staff is honoring residents' choices regarding when to get up in the morning.	

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F 242	Continued From page 2 was ready to get up. She said the day staff provided morning care for the resident, not the night staff. TMA-A said she was unaware of R170's concerns about getting up and dressed early and then being put back to bed, and denied the night staff assisted R170 to get up. She said R170 liked to get up and enjoyed socializing in the dining room in the morning. In an interview with a licensed practical nurse (LPN) A, she verified the day staff usually got the resident up each morning, but there was a male NA who worked "every couple of days" and did get him up on the night shift to use the toilet, and may have assisted the resident to dress in the early hours of the morning. LPN-A said she was unaware R170 was unhappy about the situation, and said he was capable of informing the staff of his wishes. During an interview with a registered nurse (RN)-B on 7/14/16, at 8:47 a.m. she stated that R170 was able to make his needs known, depending on the day. She explained resident choices were covered with residents by the admissions staff person. Care was dictated by the resident, and everyday could be different for the resident. If R170 wanted to stay in bed or take a bath on a different day, he just needed to tell the staff of his wishes. RN-B said night staff were not assisting residents to get up at 4:00 a.m. and said "He did not bring this up at care conference." RN-B said nursing staff should have been gathering information regarding resident care preferences at the time of the resident's admission. During a follow up observation and interview on 7/14/16, at 8:41 a.m., R170 was up and dressed	F 242	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** DON/Designee	

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F 242	Continued From page 3 for the day. When asked what time he got up he replied that it was about 4:00 a.m. and then he went back to be dressed. R170 then stated he did not "really care" and did not wish to make a complaint about it or tell the staff it was not what he wanted. An interview was conducted with the licensed social worker (LSW), who was responsible for care conferences and resident concerns on 7/14/16, at 9:28 a.m. She noted that the residents were able to voice concerns to her and that she does not have concerns related to R170 and was not aware of his complaint that he is getting up and dressed early in the a.m. and being put back to be dressed. She is not aware of who assists the resident with preferences and choices at admission and says it should be the responsiblity of the nurse manager (NM). The LSW stated that preferences such as this should be noted on the assisted daily living flow sheet (ADL) for the CNA to know. She did verify that the patient care conference notes should be completed prior to care conference or just after the conference. She verified that these were not completed by the nursing department. There was no evidence of having discussed resident preference or personal choices such as when to get up. During an interview with the admissions staff person on 7/14/16 at 11:45 a.m., she stated that she does not interview the resident about preferences during the admission process. Her suggestion was to check with Activities. In an interview with the activities director on 7/14/2016 at 2:00 p.m., she noted that she does interview the residents during the Initial Activity Assessment. This is noted that the resident	F 242		

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F 242	Continued From page 4 prefers to get up at 6:30 a.m. and go to bed at 10:00 to 11:00 p.m. She stated that she does not attend patient care conferences. A review of documents on 07/13/2016 at 1:37 p.m. indicates the ADL flow sheet (not dated) used by CNA staff does not indicate time of getting up. It does note: Bath on PM /Shower, Assist to toilet/2. Oral cares every shift, 2 assist transfer and 2 with wheeled walker, feeding tube, and 1 assist ADLS. Review of care plan dated 7/27/2016 identifies preferences of activities of the facility, not the preferences for personal cares. There is no evidence of choice preferences given at the time of admission, in a review of the progress notes or in the care plan notes. The care plan notes were not complete and as noted in the interview with the LSW, they should be completed prior to patient care conference or just after the meeting. The patient care conference for R170 was on 7/13/2016.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	F272 Immediate corrective action: Resident discharged to home 7/22/2016.	

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F 272	Continued From page 5 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess bruises for 1 of 3 resident (R170) reviewed for non-pressure related skin conditions. Findings include: R170's comprehensive skin assessment had not been completed at the time of his admission on 6/25/16, nor was an assessment of the resident's skin noted in initial progress notes. In addition, an Initial Nursing Evaluation and Vitals form was completed on 6/25/16, but did not contain	F 272	**Action as it applies to others:** Residents will have comprehensive skin assessments completed upon admission in accordance with facility policy. The Skin Program policy and procedure reviewed on 8/2/2016 and remains current. Licensed Nursing Staff will be re-educated on the policy by 8/26/2016. **Date of completion:** 8/26/2016.	

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F 272	Continued From page 6 evidence the resident was admitted with bruises. R170 was interviewed on 7/12/16, at 9:20 a.m. At the time of the interview, bruises were visible to both upper and lower arms. A nursing assistant (NA)-A was interviewed on 7/13/16, at 1:08 p.m. She reported R170's bruises had been healing since his admission. A licensed practical nurse (LPN)-A stated on 7/13/16, at 1:18 p.m. she noted R170 had multiple bruises on his arms as well as other areas on his body. Some of the resident's fingers were bruised, and his toes were used for blood glucose testing. Some of the bruises were related to insulin injections as well as intravenous infusions prior to admission. LPN-A stated, "His skin is super fragile and he bumps his arms. He came in with many Optifoams [protective skin dressings] to his arms." In an interview with a registered nurse (RN)-B on 7/14/16, at 8:52 a.m. she explained R170 had been admitted to the facility from the hospital with surgical wounds and multiple bruises. RN-B reviewed R170's record for the skin assessment and stated, "I am not saying it was not done, but I am saying that this one is blank and there are not any others found." The facility's 4/16 Skin Program policy directed staff as follows: "On admission a baseline assessment of the resident's skin status will be completed within 2 hours of admission. This will include a physical exam of the resident's skin, a risk assessment using a Risk Assessment tool, and a comprehensive assessment of the resident's history and physical condition."	F 272	**Recurrence will be prevented by:** Random weekly chart audits will be completed to ensure newly admitted residents have completed comprehensive skin assessments. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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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, 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 record review, the facility failed to identify and monitor bruising for 1 of 3 residents (R170) reviewed for non-pressure related skin conditions. Findings include: R170 was interviewed on 7/12/16, at 9:20 a.m. At the time of the interview, bruises were visible to both upper and lower arms. During an interview with the resident the following day at 1:08 p.m. he said the bruises were present at the time of his admission to the facility. R170 explained that while hospitalized he had been administered Percocet (narcotic-pain-medication) for arthritic pain and he experienced "bad nightmares." He sustained the bruises when a hospital staff person held his arms down so he would not hurt himself. R170 denied being hurt or sustaining the bruises at the facility. He reported he was legally blind in both eyes and had been prescribed blood thinner medication (known to contribute to bruising) in the past. A nursing assistant (NA)-A was interviewed on 7/13/16, at 1:08 p.m. She reported R170's	F 309	F309 (D) **Immediate corrective action:** Resident discharged to home on 7/22/2016. **Action as it applies to others:** Residents will have comprehensive skin assessments completed upon admission in accordance with facility policy. The Skin Program policy and procedure reviewed on 8/2/2016 and remains current. Licensed Nursing Staff will be re-educated on the policy by 8/26/2016. **Date of completion:** 8/26/2016.	

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F 309	Continued From page 8 bruises had been healing since his admission. R170 required standby assistance to use a walker, his walking ability was improving as well. During an observation of R170 on 7/13/16, at 1:15 p.m. the resident was self-propelling his wheelchair in the hallway when he ran into the wall and handrails, bumping his right hand and arm. When asked about this, he said the problem was not related to his poor vision, rather the "chair just went that way." A licensed practical nurse (LPN)-A stated on 7/13/16, at 1:18 p.m. she noted R170 had multiple bruises on his arms as well as other areas on his body. Some of the resident's fingers were bruised, and his toes were used for blood glucose testing. Some of the bruises were related to insulin injections as well as intravenous infusions prior to admission. LPN-A stated, "His skin is super fragile and he bumps his arms. He came in with many Optifoams [protective skin dressings] to his arms." In an interview with a registered nurse (RN)-B on 7/14/16, at 8:52 a.m. explained R170 had been admitted to the facility from the hospital with surgical wounds and multiple bruises. The resident was known to self-transfer and was not always careful with the door when going outside. The staff had provided reminders to the resident to use caution when going in and out of the doors, but the resident was "often angry" and was not compliant. RN-B said R170 did not want to reside at the facility and wanted to instead go home. RN-B stated, "He is not going to listen to what the staff has to say." She added that R170 could have sustained bruises due to "every day encounters with the environment," but staff would	F 309	**Recurrence will be prevented by:** Random weekly chart audits will be completed to ensure newly admitted residents have completed comprehensive skin assessments. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 309	Continued From page 9 continue to educate the resident. R170's electronic health record (EHR) revealed the resident was admitted to the facility on 6/25/16 with diagnoses including edema (excess fluid in the tissues), type 2 diabetes mellitus, basal cell carcinoma of skin, and macular degeneration (causing blindness). The resident had physician orders including insulin for diabetes, and hydrocortisone cream to affected areas. The use of Coumadin (blood thinner) was not noted. A comprehensive skin assessment had not been completed at the time of the resident's admission, nor was an assessment of the resident's skin noted in initial progress notes. RN-B reviewed R170's record for the skin assessment and stated, "I am not saying it was not done, but I am saying that this one is blank and there are not any others found." An Initial Nursing Evaluation and Vitals form was completed on 6/25/16, but did not contain evidence the resident was admitted with bruises. The electronic treatment record (TAR) dated 6/28/16 indicated weekly weights and vitals signs, as well as skin checks were to be competed by staff every Tuesday on the evening shift. Although staff had signed off weekly the skin checks had been completed, there was no evidence of the actual evidence of those skin checks with monitoring for healing. R170's care plan addressed skin issues in relation to the healing right ear wound, however, lacked identification of the resident's potential for or presence of bruising. The facility's 4/16 Skin Program policy directed staff as follows: "On admission a baseline assessment of the resident's skin status will be	F 309		

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F 309	Continued From page 10 completed within 2 hours of admission. This will include a physical exam of the resident's skin, a risk assessment using a Risk Assessment tool, and a comprehensive assessment of the resident's history and physical condition."	F 309		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal	F 334	F334 (E) **Immediate corrective action:** Residents R3, R7, R115, R18, and R60 were offered PCV13 according to CD guidelines and in accordance with facility policy and procedures.	

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F 334	Continued From page 11 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policies related to pneumococcal vaccinations including pneumococcal conjugate vaccine (PCV13) and	F 334	**Action as it applies to others:** All current residents who PCV13 vaccine is recommended for, and who have not already received a pneumococcal vaccination, will be offered the PCV13. To be completed by 8/26/2016. All new admissions that the PVC13 is recommended for, and who have not already received a pneumococcal vaccination, will be offered the PCV13. **Recurrence will be prevented by:**	

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F 334	Continued From page 12 pneumococcal polysaccharide vaccine (PPSV23) for 5 of 5 residents (R3, R7, R115, R18, R60) whose vaccination histories were reviewed. Findings include: 1) R3's Immunization Report dated 10/15/11, indicated the 83 year old resident had received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) on 10/15/11, but never been offered the PCV13. 2) R7's Immunization Report dated 5/7/09, indicated the 95 year old resident had received a PPSV23 vaccine on 12/7/09, but had never been offered the PCV13. 3) R115's Immunization Report dated 7/10/06, indicated the 99 year old resident had received a PPSV23 vaccine on 4/22/15, but had never been offered the PCV13. 4) R18's Immunization Report dated 12/1/09, indicated the 74 year old resident had received the PPSV23 vaccine on 4/15/09, but had not been offered a PCV13. 5) R60's Immunization Report dated 9/6/13, indicated the 89 year old resident had received the PPSV23 vaccine on 9/6/13, but had not been offered a PCV13. When interviewed on 7/14/16, at 2:35 p.m. the infection control nurse explained, "PVC 13 is not being offered to any of the residents. It was a decision that was made to not offer due to the cost." The facility's 9/15, Pneumococcal	F 334	Random weekly audits will be completed to ensure newly admitted residents for whom the PCV13 is recommended have been offered and have received (if they choose) the vaccination. Audits will be completed for a period of 90 days and results reviewed by the QA committee to determine the need for ongoing audits. **The correction will be monitored by:** Director of Nursing and/or designee.	

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	245067	A. BUILDING _____ B. WING _____	07/14/2016

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F 334	Continued From page 13 Vaccination-Resident/Patient policy directed, "All residents who previously received PPSV23 at age 65 or older: 1. Resident should receive PCV13 (one) 1 year or more after the PPSV23 dose was administered."	F 334		

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

F5067024

PRINTED: 07/22/2016
FORM APPROVED
OMB NO. 0938-0391

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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 - State Fire Marshal Division. At the time of this survey, St Lucas Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	APPROVED Tom Linhoff By Tom Linhoff at 2:52 pm, Aug 03, 2016	

RECEIVED
AUG - 3 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joe Dubbelde	ADMINISTRATOR	8/3/16

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. The St Lucas Care Center was constructed at 5 different times., The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor are used for health care). In 1960 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and the 4 additions and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a	K 000		

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K 000	Continued From page 2 fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 73 at the time of the survey.	K 000		
K 018 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least	K 018	**K018E** **Immediate corrective action:** Room # 109 and room # 19, doors were repaired immediately to close properly according to life safety code standard. This was done on July 15th, 2016 All fire doors will be checked routinely to ensure they close all the way. Director of maintenance and Administrator will review to ensure compliance.	

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K 018	Continued From page 3 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 During the facility tour between the hours of 10:00 AM and 12:30 PM on 07/14/2016, observation revealed that the resident room 109 and the soil utility room 19 doors did not close when tested.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.	K 027	**K027E** **Immediate corrective action:** Smoke barrier door next to Room #134 was repaired immediately to close according to life safety code. This was completed on July 15th, 2016 All fire doors will be checked routinely to ensure they close all the way. The director of maintenance and Administrator will review to ensure compliance.	

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K 027	Continued From page 4 Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 During the facility tour between the hours of 10:00 AM and 12:30 PM on 07/14/2016, observation revealed that the smoke barrier door next to 134 did not close when tested.	K 027	K034D **Immediate Corrective action:** All stairways and smoke proof enclosures were inspected immediately and any storage items were removed to ensure compliance with the fire safety code. This was completed on July 15th, 2016	
K 034 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3; 19.2.2.4 This STANDARD is not met as evidenced by: Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 During the facility tour between the hours of 10:00 AM and 12:30 PM on 07/14/2016, observation revealed storage was found under south stairs going to basement level.	K 034		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not	K 066	All stairways and smoke proof enclosures will be inspected routinely to ensure no storage items are there. Director of maintenance and Administrator will review to ensure compliance.	

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K 066	Continued From page 5 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 During the facility tour between the hours of 10:00 AM and 12:30 PM on 07/14/2016, observation revealed that there were no signage for Non-smoking facility at all exit doors.	K 066	K066F **Immediate Corrective action:** Director of maintenance ordered signage for identifying the building as smoke free for all doors. This was completed on July 15th, 2016 Signage arrived at facility on July 19th and all doors immediately had signage installed. Director of maintenance and Administrator will review to ensure compliance to the Fire safety K tag.	

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