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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LPM8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00116

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245372**

2.STATE VENDOR OR MEDICAID NO.
(L2) **428540900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUKES LUTHERAN CARE CENTER**
(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

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 **12/14/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **79** (L18)
13.Total Certified Beds **79** (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
	79			
(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 :
Elizabeth Silkey, Unit Supervisor 12/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/30/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

CMS Certification Number (CCN): 245372

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

Dear Administrator:

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 December 6, 2021 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2021

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: October 28, 2021

Dear Administrator:

On November 19, 2021, we notified you a remedy was imposed. On December 14, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 6, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 3, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 19, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 6, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LPM8

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(L2) **428540900**

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(L4) **1219 SOUTH RAMSEY**
(L5) **BLUE EARTH, MN** (L6) **56013**

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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 **10/28/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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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**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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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)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

17. SURVEYOR SIGNATURE Date :
Kari Witte, HFE NE II 12/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/17/2021 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

Electronically delivered
November 19, 2021

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: October 28, 2021

Dear Administrator:

On October 28, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 3, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 3, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Lukes Lutheran Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 April 28, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY BLUE EARTH, MN 56013**

(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
E 000	Initial Comments On 10/25/21 - 10/28/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		12/6/21

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

Electronically Signed | 11/26/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY BLUE EARTH, MN 56013**

(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
E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY BLUE EARTH, MN 56013**

(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
E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the Emergency Power Supply System per NFPA 99 (2012 edition), Health Care Facilities Code,	E 041	On 11/30/21, Interstate Power will be completing load-bank testing on the facility's generator. The Building Services Director will be responsible for scheduling	

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	245372	A. BUILDING _____ B. WING _____	C 10/28/2021

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E 041	Continued From page 3 section(s) 6.4.1.1, 6.4.4.1.3, 6.5.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/26/2021 between 12:30 p.m. to 3:00 p.m., it was revealed during documentation review that no documentation was presented for review to confirm that the facility emergency generator was being load-bank tested at least once within every 36 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	the completion of load-bank testing at least once within every 36 months. The Building Services Director is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	
F 000	INITIAL COMMENTS On 10/25/21 - 10/28/21. a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5372033C (MN77129) H5372036C (MN56083) H5372037C (MN61812) H5372038C (MN67603) H5372040C (MN71270) The following complaints were found to be	F 000		

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F 000	Continued From page 4 UNSUBSTANTIATED: H5372035C (MN64739), H5372034C (MN67147) and H5372039C (MN68195). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		12/6/21

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F 688	Continued From page 5 by: Based on observation, interview and document review the facility failed to ensure a range of motion program for lower extremities was completed for 1 of 2 residents (R12) reviewed with limited range of motion. Findings include: R12's face sheet, printed 10/27/21, indicated an admission date of 7/16/21 and identified diagnoses of paraplegia (paralysis of all or part of your trunk, and legs), intraspinal abscess (pus filled blisters between the spinal cord and backbone), obesity, and polyneuropathy (nerve damage). R12's admission Minimum Data Set (MDS) assessment dated 7/22/21, identified R12 had intact cognition, limited range of motion of both lower extremities and required extensive assist of 2 or more persons for transfers, bed mobility and bathing. R12's Range of Motion Observation and Assessment dated 7/22/21, and 10/20/21, indicated R12 had very limited ability to perform ADL's, is non-ambulatory, and requires passive and active range of motion. R12 is able to complete upper range of motion but requires assistance with lower extremity as R12 is paraplegic, has sensation of pressure to lower body, is unable to ambulate and has no significant range of motion restrictions noted but joints are stiff. R12's care plan dated 8/3/21, indicated R12 has an alteration in activities of daily living (ADL's) is independent with upper body after setup, but	F 688	St. Luke's Lutheran Care Center is committed to providing a range of motion program to improve or maintain residents' joint mobility and muscle strength. Even though the nursing assistant Resident Assignment sheet stated that R12 was to receive range of motion exercises daily with am cares, the nursing assistant staff did not consistently provide the exercises as directed. A copy of the range of motion exercises developed by the Therapy Department was in the comprehensive care plan binder. A copy has been placed in R12's In-Room Care Plan folder in the resident's bathroom; an approach for ROM exercises is also written in R12's comprehensive care plan. To assure that R12 and other residents receive range of motion exercises as directed, the station charge nurse or designee will be responsible for checking with the resident and nursing assistant to see if the nursing assistant performed range of motion exercises as directed. The RN Resident Care Coordinator or charge nurse will be responsible for entering a nursing order in the resident's electronic health record for the station charge nurse to verify completion of exercises scheduled during their shift and document this verification in the resident's electronic medication and treatment record. The charge nurse verification and documentation step has been added to the facility's Range of Motion Procedure. On 10/27/21, the Director of Nursing posted a memo at each nursing station	

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F 688	Continued From page 6 requires staff assist with washing and drying back and lower body. The care plan did not include a restorative or range of motion program. A physician discharge order dated signed by the therapist on 7/28/21, and the physician on 8/7/21, indicated the resident will be discharged with nursing to complete the lower extremity range of motion program. Point of Care range of motion documentation sheet indicated range of motion once a day was completed five times in August, eight times in September, and seven times in October, 2021. During interview on 10/25/21, at 2:34 p.m., R12 indicated he has paralysis with loss of feeling in his lower half of his body. R12 indicated he can move his legs some, but not his feet. R12 demonstrated minimal movement of both lower extremities and was unable to lift his legs off the mattress. R12 further indicated he has not had therapy on his legs since he came to the facility and staff have not completed range of motion on his legs since therapy ended. During interview on 10/27/21, at 9:08 a.m., physical therapist (PT) indicated R12 received therapy upon admission in July 2021 and upon discharge a range of motion program was prescribed for his legs. PT indicated nursing was given a print out of exercises to complete with pictures and and listed how often to complete. PT stated R12 is not capable of doing the lower extremity range of motion without assistance. During interview on 10/27/21, at 9:26 a.m., registered nurse (RN)-A indicated the range of motion to lower legs program was listed on the	F 688	with instructions that nursing staff read during shift report through 11/7/21, and sign and date after reading. The memo discussed the importance of completion of range of motion exercises at the frequency specified in the care plan, as well as importance of NA documentation of completion in Matrix Care Assist. The memo instructed charge nurses to check with the nursing assistant and resident to verify completion of exercises and document completion in EMAR. The facility's Range of Motion Exercise Procedure is included in the Licensed Nurse Orientation Checklist and Nursing Assistant Orientation Checklist for all new Nursing Department employees. On a weekly basis for one month and then monthly, the Director of Nursing or her designee will randomly audit documentation of verification of ROM cares by nursing assistant staff in Matrix Care Assist and documentation of nurse verification of ROM cares in residents' EMAR. On a monthly basis, the Staff Development RN or her designee will randomly audit completion of range of motion exercises during nursing assistant care audits. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 688	Continued From page 7 daily task sheets for the nursing assistants to complete, but was not completed daily. During interview on 10/27/21, at 9:34 a.m., nursing assistant (NA)-A indicated she was unsure if R12 received range of motion exercises. During interview on 10/27/21, at 9:36 a.m., NA-B indicated she was unsure if R12 required range of motion exercises initially but after looking at the nursing assistant care sheet, NA-B stated it is listed to complete every a.m. while in bed. During interview on 10/27/21, at 9:44 a.m., R12 indicated he has not had any range of motion exercises since 10/25/21. During interview on 10/27/21, at 10:10 a.m., RN-B indicated generally range of motion instructions from therapy are posted in the bathroom, but R12 did not have any posted. RN-B did locate the instructions in a communication binder at the nurses station that included instructions for range of motion exercises to be completed for 5 exercises including diagrams with hand written note stating NA's to do with a.m. cares. During interview on 10/28/21, at 8:42 a.m., the director of nursing confirmed the range of motion wasn't completed daily and it should have been. The DON was able to locate the instructions in the communication book but indicated it should have been posted in the bathroom but was not. Facility policy and procedure titled "Range of Motion" undated, included: - The purpose is to move the resident's joints through as full a range of motion as possible, to	F 688	Completion Date: 12/6/21	

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F 688	Continued From page 8 improve or maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent complications of immobility. -General resident care plan documentation guidelines included identify the appropriate problem under which to list range of motion as an approach . Facility document titled "Procedure: Range of Motion" dated 10/18 included: - A range of motion assessment will be completed on each resident upon admission, quarterly, annually and significant change. - The therapy department will be contacted to screen residents if indicated for concerns related to joint mobility. - The resident or his/her responsible party will be contacted if therapy staff recommends an evaluation. If approved, the resident's physician will be contacted and a request for a therapy evaluation will be made. - Therapy recommendations for range of motion exercises and/or mobility maintenance program will be added to the resident care plan.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		12/6/21

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F 812	Continued From page 9 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization for 1 of 1 dishmachine was appropriately monitored. In addition, the facility failed to date-mark opened containers of food in 1 of 1 kitchen refrigerator, and to ensure pans were completely dry before storing. Furthermore, the facility failed to ensure dietary staff received required training on an on-going basis for 3 of 3 staff: culinary services director (SD)-D, assistant director of culinary services (ADCS)-E, and cook (C)-A. This had the potential to affect all 64 residents who were served food from the kitchen. Findings include: During an observation and interview on 10/25/21, at 1:00 p.m., with SD-D and during the initial tour of the kitchen, observed a large metal bowl in a walk-up refrigerator. The bowl was covered with plastic wrap and aluminum foil. Handwritten on the foil was "BRN (bran) cookies" and date of "10/13." Inside was dark colored, raw dough. CSD-D stated the dough was for bran cookies and was good for a couple of weeks. Observed multiple jelly roll plans stacked upside down. CSD-D was asked to look at the first few, and the surfaces were noted to be wet. CSD-D directed	F 812	St. Luke's Lutheran Care Center Food Storage Policy states that leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. All food items will be checked to assure that foods will be consumed by their "safe used by dates" or discarded. On 10/27/21, the Director of Culinary Services assured that all open containers of refrigerated food were covered, labeled, and dated following facility policy. On an ongoing basis, the Director of Culinary Services or designee will conduct random weekly audits of open containers of refrigerated foods to assure compliance with facility food storage policy. On 10/27/21, the Ecolab representative trained Director of Culinary Services and dietary staff in the use of the 3-compartment sink. On an ongoing basis, the Director of Culinary Services or designee will conduct random weekly audits of completed sanitizer logs and staff setting up and testing sanitation levels in the 3-compartment sink. On 10/27/21, the Director of Culinary Services assured that staff present were	

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F 812	Continued From page 10 staff to run them through the dishmachine again. Observed multiple cutting boards stacked vertically, touching one another. CSD-D acknowledged inappropriate storage of pans and cutting boards could create an environment for bacteria to grow. Observed a three-compartment dish washing sink. The monitoring log hanging on a near by cupboard door was blank for the month of October. During an observation on 10/26/21, at 11:00 a.m., the bowl of bran cookie dough in large metal bowl was still in the refrigerator. At the three-compartment sink, an Ecolab Smart Power Sink and Surface Cleaner Sanitizer instructional poster was posted above the sink. Ecolab Sink and Surface Cleaner Sanitizer Test strips with expiration date of 8/2022, were noted on the ledge above the sink. According to Ecolab website, measurements of the chemical sanitizing solution could be taken at any temperature above 65 degrees Fahrenheit. Measurement required a five second dip into the test solution, allowing 10 seconds for the color change to occur, and compare the strip against the color chart on the vial. The required ppm (parts per million) DDBSA (dodecylbenzenesulfonic acid) and ppm lactic acid was outlined by a black box on the color chart. During an interview and observation on 10/26/21, at 11:08 a.m. ADCS-E stated he had no format training for his role, adding he was going to start working on his CDM (certified dietary manager). ADCS-E stated he did not have ServSafe certification as it had expired. When asked what kind of training he had on the three-compartment sanitizer sink, ADCS-E replied, "Not a whole lot." While standing at the three-compartment sink	F 812	re-educated on assuring all pans are completely dried prior to stacking. A commercial cutting board rack was ordered for drying and storage of cutting boards. On an ongoing basis, the Director of Culinary Services or designee will conduct random weekly audits of proper pan and cutting board drying and storage. On 11/30/21, the Director of Culinary Services will hold a mandatory Food Service Training Meeting for all dietary staff that will cover the following topics: 1. Food storage and labeling 2. 3-Compartment Sink training including procedure for monitoring the sanitizing solution 3. Drying and Storage of cutting boards and pans On an ongoing basis, all dietary staff will receive training upon hire on the above topics. Results of the Dietary Department auditing will be summarized by the Director of Culinary Services at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Culinary Services is responsible for overall compliance with this regulation. Completion Date: 12/6/21	

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with ADCS-E and C-A, both stated they had not had training on monitoring and measuring the level of chemical. C-A used a test strip and inserted it in the first sink filled with water and chemical. When asked how long the strip was to be kept in the water, C-A replied "30 seconds." The container of strip container indicated 5 seconds. Then C-A held the strip against the color chart on the vial, but wasn't sure which number to read and record: ppm DDBSA or ppm lactic acid.

During an interview and observation on 10/26/21, at 11:30 a.m., with ADCS-E and C-A at the walk-up refrigerator, C-A was asked to remove the bowl of bran dough. C-A stated they made and served bran cookies on Wednesday and Sunday nights. C-A stated the dough was good for two to three weeks, but but admitted there was nothing that indicated that. C-A obtained the recipe to see if it indicated how long the dough lasted in the refrigerator. It was a hand-written recipe on a card and did not include shelf-life for the raw dough. C-A stated they should probably make smaller batches of dough. At 11:34 a.m., with ADCS-E in walk-in refrigerator, observed a container of Mrs. Gerry's potato salad with approximately one-fourth left. The container did not have a date opened mark on it. ADCS-E stated, "It's not dated; its supposed to be dated," adding if dated, it would be good for five days. A container of Monarch brand salad dressing was observed with approximately one-eight left in the container; the container did not have a date opened mark on it. ADCS-E stated it should have been dated, then discarded after being opened for five days. A large bunch of green onions wrapped in plastic were observed with received date of 9/22. ADCS-E did not know if they were

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still okay to serve residents; he would need to inspect them. ADCS-E stated there wasn't a policy or reference tool that he was aware of for knowing how long produce and opened foods were good for, adding "we say left-overs are good for seven days -- no matter what it is, and 5 days for vendor packaged food like potato salad."

During an interview on 10/27/21, at 9:15 a.m., CSD-D could not recall when training was provided to staff on the three-compartment sink, including monitoring the sanitizing solution. CSD-D admitted she was to be the expert for this process, but did not recall the last time she had training. In addition, CSD-D admitted it was her responsibility to oversee staff to ensure they followed regulations and monitored the effectiveness of the sanitizing solution. CSD-D stated she reminded staff on Monday (10/25/21), to test it. CSD-D was informed that staff had not tested the solution the past two days because they stated did not know how. CSD-D stated the Ecolab representative was scheduled to come today for staff training.

During the same interview, CSD-D stated unopened foods were good until the manufacturer best by or expiration date, and opened foods were good for five days. CSD-D stated staff were to date food when opened, but admitted she did not monitor this. CSD-D was informed of potato salad and salad dressing being opened, but not dated, and of green onions from September. CSD-D stated the potato salad, salad dressing and onions should be discarded. In addition, CSD-D stated she looked up how long the bran cookie dough was good for and learned it was good for a week. CSD-D admitted the dough in the refrigerator was 14 days old, would be

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F 812	Continued From page 13	F 812		

discarded and smaller batches made going forward. Furthermore, CSD-D could not say, nor provide records that staff had specific training on dating foods when opened, how long foods were good for after opening, letting pans dry before stacking, and not stacking cutting boards.

During an interview on 10/27/21, at 12:22 p.m., the Ecolab representative stated he trained CSD-D and staff how to measure the sanitizing solution in the three-compartment sink. CSD-D provided a list of six staff, plus herself, who received the training.

During an interview on 10/28/21, 13:27 p.m. the administrator stating she was aware of the findings with the three-compartment sink, but not the wet pans, bran dough, and foods not labeled after opening. The administrator stated after findings from the last survey, she didn't expect this, adding she expected staff to be monitoring this and following regulations.

During an observation and interview on 10/28/21, at 10:00 a.m., C-C stated she had training on 10/27, with the Ecolab representative on measuring the sanitizing solution. Observed the three compartment sinks filled with water and solution, but the monitoring log was empty for this date. C-C stated she had been too busy to test the solution. At that point, C-C tested the solution and wrote the information on the log hanging on the cupboard door.

Facility policy titled Cleaning Dishes - Manual Dishwashing, dated 2010, indicated dishes and cookware would be washed after each meal to assure all dishes were clean and sanitary. Check sanitation sink often using a test strip to assure

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY BLUE EARTH, MN 56013**

(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 812	Continued From page 14 the level of sanitation solution is appropriate. Test the sanitizing solution in the sink using the manufacturers suggested test strips to assure appropriate level. Allow dished to air dry. Check all dishes to be sure they are clean and dry prior to storing. Facility policy titled Food Storage, dated 2010, indicated date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed or discharged, will be visible on all high risk foods. Left-over food is clearly labeled and dated before being refrigerated. Leftover food is used within 5 days or discarded. All food should be labeled and dated. All foods will be checked to assure that foods (including leftovers) are consumed by their safe use dates or discarded.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		12/6/21

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F 880	Continued From page 15 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 16 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control measures were maintained for indwelling urinary catheter care for 1 of 1 resident (R43) reviewed for catheter care. Furthermore, the facility failed to ensure hand hygiene was performed during resident care and meal-tray passes for 3 of 3 residents (R43, R54 and R41) observed for infection control practices. Findings include: R43's diagnosis reported printed 10/28/21, included diagnoses of urinary retention, past history of urosepsis (a life threatening complication of an infection caused a urinary tract infection), and urinary tract infection. R43's significant change Minimum Data Set (MDS) assessment dated 9/3/21, indicated R43 was cognitively intact, had adequate hearing and vision, clear speech, was able to make herself understood and could understand others. The MDS further indicated R43 had an indwelling urinary catheter, and required total dependence of one staff for moving about the facility in a wheelchair. R43's physician order dated 7/14/21, indicated	F 880	St. Luke□s Lutheran Care Center has a well-established infection prevention and control program that includes procedures for hand hygiene and urinary catheter bag care. The facility□s Urinary Catheter Use, and Care Guide is written with the goal that residents with an indwelling catheter shall be free from complications of infection. Positioning of the closed urinary drainage system is an essential element of infection prevention. On 10/28/21, a 3M Command Hook was mounted on a bookcase next to R43□s recliner for catheter bag placement when the resident is sitting in a recliner. A bungy cord was attached to R43□s wheelchair frame under the wheelchair seat to allow positioning of the catheter bag without floor contact. A plan for safe options for catheter bag placement while sitting in a chair or lying in a bed has been made for each resident who has a catheter. On an ongoing basis, the RN Resident Care Coordinator and station nursing staff will develop a plan for safe options for catheter bag placement for each resident with a catheter. On 10/29/21, the Director of Nursing	

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F 880	Continued From page 17 indwelling catheter due to urine retention with recurrent urinary tract infections. R43's care plan problem dated 12/14/17, indicated R43 had urinary retention. In addition, a care plan problem dated 12/16/20, indicated there was the potential for overall decline and complications related to history of hospitalization for urinary tract infection with sepsis. During an observation on 10/25/21, at 4:58 p.m., observed R43's urinary drainage bag laying directly on the floor to the right of her recliner. During an observation on 10/25/21, at 5:04 p.m., R43 was observed being transported to the dining room via wheelchair. The bottom of R43's urinary drainage bag which was hooked to the underside of the wheelchair, and was dragged along the floor to the dining room. During an observation on 10/26/21, at 3:25 p.m., R43's urinary drainage bag was observed hooked to the side of her wastebasket which was to the right of her recliner, with the bottom of the bag touching the floor. Hand Hygiene During an observation and interview on 10/25/21, at 4:45 p.m., observed trained medication aide (TMA)-B enter R41's room and set her meal tray on an overbed table. TMA-B woke R41, helped her out of bed, opened the curtains, assisted her to ambulate to the recliner and set up her meal tray. TMA-B exited the room without performing hand hygiene. A hand sanitizer dispenser was observed on the wall near the door. At 4:48 p.m.,	F 880	posted a memo at each nursing station with instructions that nursing staff read it during shift report through 11/7/21, and sign and date after reading. The memo included re-education on catheter bag care including the facility expectation that a catheter bag should never touch the floor or be attached to a waste basket. The memo also included re-education on hand hygiene including the facility expectation that hand hygiene should occur before, during and after each resident□s care was complete. On an ongoing basis, hand hygiene and urinary catheter bag care are included in the orientation checklist for new licensed nurses and nursing assistants. On a weekly basis for one month and then monthly, the Infection Prevention and Control RN or her designee will randomly audit catheter bag care and hand hygiene. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation. Completion Date: 12/6/2021 Please see the attachments for Infection Control	

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F 880	Continued From page 18	F 880		

TMA-B took a meal tray into R54's room and set it on an overbed table. TMA-B helped R54 up from bed, put her shoes on, placing her palm on the bottom of the shoes to get them in place, assisted her into a wheelchair, then to a recliner, then set up her tray. TMA-B exited the room without performing hand hygiene. A hand sanitizer dispenser was observed on the wall near the door. At 4:58 p.m., TMA-B entered R43's room without performing hand hygiene, donned gloves, emptied R43's urinary drainage bag into a urinal. TMA-B emptied the urinal into the toilet, flushed the toilet and removed her gloves. No hand hygiene was performed. TMA-B donned new gloves and helped a nurse with a mechanical lift to transfer R43 into a wheelchair. Once the transfer was complete, with gloved hands, TMA-B opened the curtains, and then removed her gloves. At 5:02 p.m., while standing near the door in R43's room, TMA-B made notations on paper documents, then folded them and tucked them behind R43's hand sanitizer dispenser, performed hand hygiene and exited the room. TMA-B was asked if she cleaned her hands in between resident rooms when delivering meal trays for R41 and R54, and providing care to R43, TMA-B stated she thought she did. When informed it was not observed, TMA-A stated she was sorry, and should have. TMA-B confirmed hand hygiene was important to prevent the spread of germs between residents.

During an interview on 10/28/21 at 9:13 a.m., the DON was asked if it was acceptable practice to hang a urinary drainage bag from a wastebasket or lay it directly on the floor and she replied it was not acceptable, adding it was not appropriate due to possible contamination. The DON was informed of the observations of R43's urinary

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F 880	Continued From page 19	F 880		

drainage bag secured to the wastebasket in her room, laying on the floor, and being dragged along the floor underneath her wheelchair. The DON stated "that should never happen happen, that's not okay...it shouldn't be on the floor or hanging from the wastebasket." In addition, when informed of observations of lack of hand hygiene between resident cares, the DON stated staff were expected to clean their hands when entering and exiting a residents room to prevent cross contamination, adding they educated staff on that all the time.

During an interview on 10/28/21, at 12:47 p.m., the administrator was informed of findings related to lack of hand hygiene between resident cares, and handling of a urinary drainage bag. The administrator stated she expected staff to perform hand hygiene between residents and acknowledged dispensers were readily available in each resident room, so there was no excuse not to do hand hygiene.

Facility policy titled Policy and Procedure for Hand Hygiene with revised date of 11/2017, indicated the policy was based on CDC guidelines. The policy directed staff to wash hands with soap and water when visibly soiled, and at a minimum before and after each resident contact and after handling any contaminated items. When hands were not visibly soiled, alcohol-based hand rub for decontaminating hands in all other clinical situation. Examples included before and after any resident contact, and before donning gloves.

Facility policy titled Urinary Catheter Use and Care Guide dated 11/2004, indicated the resident with an indwelling catheter shall be free from

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F 880	Continued From page 20 complications of infection. Hands would be washed before and after performing any procedure for residents with urinary catheters.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/26/2021. At the time of this survey, ST LUKES LUTHERAN CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/26/2021

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST LUKES LUTHERAN CARE CENTER is a 1 story building with partial basement. The original building was constructed in 1963, is one-story in height, has a partial basement, and was determined to be of Type II (111) construction. In 1969 an addition was constructed, one-story in height with no basement, and was determined to be of Type II (111) construction. In 1975 an addition was	K 000		

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K 000	Continued From page 2 constructed, one-story in height with no basement, and was determined to be of Type II (111) construction. In 2005 an addition was constructed, one-story in height with no basement, and was determined to be of Type V (111) construction. In 2008 an mechanical building addition was constructed, one-story in height with no basement, and was determined to be of Type II (111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 79 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		12/6/21

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K 324	Continued From page 3 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Ansul type fire extinguishing equipment in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 9.2.3, and 19.3.2.5.3(10), NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Standard for Wet Chemical Extinguishing Systems, section 7.5.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 10/26/2021 between 12:30 PM to 03:00 PM, it	K 324	Arrangements have been made for Fairmont Fire Systems to come to St. Luke's Lutheran Care Center during the week of 11/29/21 to conduct Hydrostatic testing of the facility's Ansul type fire suppression system. Hydrostatic testing is to occur on a 12-year cycle. On an ongoing basis, the Building Services Director will be responsible for assuring that testing occurs within the 12-year testing cycle. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	

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K 324	Continued From page 4 was revealed during a review of available documentation that the last hydrostatic test of the Ansul type fire suppression system occurred in 2005. Hydrostatic testing is to occur on a 12-year cycle; as such, the system should have been tested in 2017. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6,	K 353	On 11/11/21, sprinkler heads that exhibited signs of oxidation were replaced. On 11/24/21, items that were noted to be placed closer than eighteen	12/6/21

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2021**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, 5.2.2.2. NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 10/26/2021 between 10:00 AM to 12:30 PM, it was revealed by observation that in the Kitchen dish-washing area, the Dining Area, and Room B205 that sprinkler heads exhibited signs of oxidation 2. On 10/26/2021 between 10:00 AM to 12:30 PM, it was revealed by observation that items were placed closer than eighteen inches to the sprinkler head(s) in the following locations: Volunteer Services Office, A319, A321, A324, A326, M714, M704, L509, D125, D122, D124, D123, D115, M032 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	inches to the facility sprinkler heads were re-located to assure the required 18-inch space between items and sprinkler heads. The Building Services Director or his designee will conduct random monthly audits within the facility to assure compliance with the 18-inch space requirement between items and sprinkler heads. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective	K 374		12/6/21

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2021**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 374	Continued From page 6 plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain, test, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/26/2021 between 10:00 AM to 12:30 PM, it was revealed by observation that the smoke barrier doors of Bluebird Wing, Autumn Lane, and door set identified as 007 all had door-to-door vertical air-gaps greater than one-eighth of an inch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	Fiber strips were installed on the smoke barrier doors on Bluebird Wing, Autumn Lane, and door set 007, making the air gap between the doors less than 1/8 inch; this project was completed on 11/23/21. The Building Services Director or his designee will conduct random monthly audits of the smoke barrier doors in the facility to assure compliance with the air gap width regulation. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511		12/6/21

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2021**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 511	Continued From page 7 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and physical accessibility to an electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 10/26/2021, between 10:00 AM to 12:30 PM, it was revealed by observation that in the resident corridor of Sunrise Wing, an electrical panel was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	On 10/27/21, doors to the electrical panel located on Sunrise Wing were secured with a lock. The Building Services Director or his designee will conduct random monthly audits of the facility's electrical panels are secured. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general	K 914		12/6/21

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	245372	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/26/2021**

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ST LUKES LUTHERAN CARE CENTER	**1219 SOUTH RAMSEY** **BLUE EARTH, MN 56013**

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K 914	Continued From page 8 anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to complete receptacle testing documentation per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.2, and 6.3.4.2.1.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/26/2021 between 12:30 PM to 03:00 PM, it was revealed during a review of the available documentation that the documentation presented for review was incomplete as not all electrical outlet testing forms were dated. Undated forms do not meet the record-keeping requirements and make it undetermined whether the 2020 annual electrical outlet testing had been completed.	K 914	Updated forms for receptacle testing has been received and will be used for documentation of receptacle testing. All receptacle testing forms will be dated upon completion of receptacle testing. The Building Services Director will review all receptable testing forms for completion. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	

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K 914	Continued From page 9 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		12/6/21

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K 918	Continued From page 10 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the Emergency Power Supply System per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.4.1.1, 6.4.4.1.3, 6.5.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/26/2021 between 12:30 PM to 03:00 PM, it was revealed during documentation review that no evidence was available to confirm that the facility emergency generator was being load-bank tested at least once within every 36 months to exercise the transfer switch under the conditions of a long term power outage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	On 11/30/21, Interstate Power will be completing load-bank testing on the facility's generator. The Building Services Director will be responsible for scheduling the completion of load-bank testing at least once within every 36 months. The Building Services Director is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		12/6/21

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K 923	Continued From page 11 within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.3.4, 11.6.2.3, 11.6.5 This deficient condition could have a widespread impact on the residents within the facility.	K 923	The doors to the metal cabinet used for storage in the Medical Gas Storage Room (A314C) will be kept shut at all times that staff members are not accessing supplies from the cabinet. Oxygen cylinders with regulators applied will be stored in the empty storage racks in the Medical Gas Storage Room. A sign	

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K 923	Continued From page 12 Findings include: 1. On 10/26/2021 between 10:00 AM to 12:30 PM, it was revealed by observation that the Med Gas Storage Room (A314C) had combustible storage within 5 feet of the oxygen cylinders. 2. On 10/26/2021 between 10:00 AM to 12:30 PM, it was revealed by observation that the Med Gas Storage Room (C12A) had mixed storage of oxygen cylinders in the empty/full storage racks. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	has been posted instructing staff not to place regulators on an oxygen tank until the tank is needed. The Building Services Director or his designee will conduct random monthly audits of the facility's Medical Gas Storage Rooms to assure that metal storage cabinet doors are shut and oxygen cylinders with regulators applied are stored in the empty storage rack. Results of auditing will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Building Services is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2021

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

Re: State Nursing Home Licensing Orders
Event ID: LPM811

Dear Administrator:

The above facility was surveyed on October 25, 2021 through October 28, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00116	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/25/21 - 10/28/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5372033C (MN77129) H5372036C (MN56083) H5372037C (MN31812) H5372038C (MN67603) H5372040C (MN71270) The following complaints were found to be UNSUBSTANTIATED: H5372035C (MN64739), H5372034C (MN67147) and H5372039C (MN68195). 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing	2 000		

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2 000	Continued From page 2 orders are delineated on the attached Minnesota 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced	2 895		12/6/21

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	00116	A. BUILDING: _____ B. WING _____	C 10/28/2021

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ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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2 895	Continued From page 3 by: Based on observation, interview and document review the facility failed to ensure a range of motion program for lower extremities was completed for 1 of 2 residents (R12) reviewed with limited range of motion. Findings include: R12's face sheet, printed 10/27/21, indicated an admission date of 7/16/21 and identified diagnoses of paraplegia (paralysis of all or part of your trunk, and legs), intraspinal abscess (pus filled blisters between the spinal cord and backbone), obesity, and polyneuropathy (nerve damage). R12's admission Minimum Data Set (MDS) assessment dated 7/22/21, identified R12 had intact cognition, limited range of motion of both lower extremities and required extensive assist of 2 or more persons for transfers, bed mobility and bathing. R12's Range of Motion Observation and Assessment dated 7/22/21, and 10/20/21, indicated R12 had very limited ability to perform ADL's, is non-ambulatory, and requires passive and active range of motion. R12 is able to complete upper range of motion but requires assistance with lower extremity as R12 is paraplegic, has sensation of pressure to lower body, is unable to ambulate and has no significant range of motion restrictions noted but joints are stiff. R12's care plan dated 8/3/21, indicated R12 has an alteration in activities of daily living (ADL's) is independent with upper body after setup, but requires staff assist with washing and drying back	2 895	St. Luke□s Lutheran Care Center is committed to providing a range of motion program to improve or maintain residents□ joint mobility and muscle strength. Even though the nursing assistant Resident Assignment sheet stated that R12 was to receive range of motion exercises daily with am cares, the nursing assistant staff did not consistently provide the exercises as directed. A copy of the range of motion exercises developed by the Therapy Department was in the comprehensive care plan binder. A copy has been placed in R12□s In-Room Care Plan folder in the resident□s bathroom; an approach for ROM exercises is also written in R12□s comprehensive care plan. To assure that R12 and other residents receive range of motion exercises as directed, the station charge nurse or designee will be responsible for checking with the resident and nursing assistant to see if the nursing assistant performed range of motion exercises as directed. The RN Resident Care Coordinator or charge nurse will be responsible for entering a nursing order in the resident□s electronic health record for the station charge nurse to verify completion of exercises scheduled during their shift and document this verification in the resident□s electronic medication and treatment record. The charge nurse verification and documentation step has been added to the facility□s Range of Motion Procedure. On 10/27/21, the Director of Nursing posted a memo at each nursing station	

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2 895	Continued From page 4 and lower body. The care plan did not include a restorative or range of motion program. A physician discharge order dated signed by the therapist on 7/28/21, and the physician on 8/7/21, indicated the resident will be discharged with nursing to complete the lower extremity range of motion program. Point of Care range of motion documentation sheet indicated range of motion once a day was completed five times in August, eight times in September, and seven times in October, 2021. During interview on 10/25/21, at 2:34 p.m., R12 indicated he has paralysis with loss of feeling in his lower half of his body. R12 indicated he can move his legs some, but not his feet. R12 demonstrated minimal movement of both lower extremities and was unable to lift his legs off the mattress. R12 further indicated he has not had therapy on his legs since he came to the facility and staff have not completed range of motion on his legs since therapy ended. During interview on 10/27/21, at 9:08 a.m., physical therapist (PT) indicated R12 received therapy upon admission in July 2021 and upon discharge a range of motion program was prescribed for his legs. PT indicated nursing was given a print out of exercises to complete with pictures and and listed how often to complete. PT stated R12 is not capable of doing the lower extremity range of motion without assistance. During interview on 10/27/21, at 9:26 a.m., registered nurse (RN)-A indicated the range of motion to lower legs program was listed on the daily task sheets for the nursing assistants to complete, but was not completed daily.	2 895	with instructions that nursing staff read during shift report through 11/7/21, and sign and date after reading. The memo discussed the importance of completion of range of motion exercises at the frequency specified in the care plan, as well as importance of NA documentation of completion in Matrix Care Assist. The memo instructed charge nurses to check with the nursing assistant and resident to verify completion of exercises and document completion in EMAR. The facility□s Range of Motion Exercise Procedure is included in the Licensed Nurse Orientation Checklist and Nursing Assistant Orientation Checklist for all new Nursing Department employees. On a weekly basis for one month and then monthly, the Director of Nursing or her designee will randomly audit documentation of verification of ROM cares by nursing assistant staff in Matrix Care Assist and documentation of nurse verification of ROM cares in residents□ EMAR. On a monthly basis, the Staff Development RN or her designee will randomly audit completion of range of motion exercises during nursing assistant care audits. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation. Completion Date: 12/6/21	

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2 895	Continued From page 5 During interview on 10/27/21, at 9:34 a.m., nursing assistant (NA)-A indicated she was unsure if R12 received range of motion exercises. During interview on 10/27/21, at 9:36 a.m., NA-B indicated she was unsure if R12 required range of motion exercises initially but after looking at the nursing assistant care sheet, NA-B stated it is listed to complete every a.m. while in bed. During interview on 10/27/21, at 9:44 a.m., R12 indicated he has not had any range of motion exercises since 10/25/21. During interview on 10/27/21, at 10:10 a.m., RN-B indicated generally range of motion instructions from therapy are posted in the bathroom, but R12 did not have any posted. RN-B did locate the instructions in a communication binder at the nurses station that included instructions for range of motion exercises to be completed for 5 exercises including diagrams with hand written note stating NA's to do with a.m. cares. During interview on 10/28/21, at 8:42 a.m., the director of nursing confirmed the range of motion wasn't completed daily and it should have been. The DON was able to locate the instructions in the communication book but indicated it should have been posted in the bathroom but was not. Facility policy and procedure titled "Range of Motion" undated, included: - The purpose is to move the resident's joints through as full a range of motion as possible, to improve or maintain joint mobility and muscle strength, prevent contractures, increase strength and activity tolerance, reduce pain and prevent	2 895		

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2 895	Continued From page 6 complications of immobility. -General resident care plan documentation guidelines included identify the appropriate problem under which to list range of motion as an approach . Facility document titled "Procedure: Range of Motion" dated 10/18 included: - A range of motion assessment will be completed on each resident upon admission, quarterly, annually and significant change. - The therapy department will be contacted to screen residents if indicated for concerns related to joint mobility. - The resident or his/her responsible party will be contacted if therapy staff recommends an evaluation. If approved, the resident's physician will be contacted and a request for a therapy evaluation will be made. - Therapy recommendations for range of motion exercises and/or mobility maintenance program will be added to the resident care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to implementation of range of motion, could assure proper assessment and interventions are being implemented. The DON could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization for 1 of 1 dishmachine was appropriately monitored. In addition, the facility failed to date-mark opened containers of food in 1 of 1 kitchen refrigerator, and to ensure pans were completely dry before storing. Furthermore, the facility failed to ensure dietary staff received required training on an on-going basis for 3 of 3 staff: culinary services director (SD)-D, assistant director of culinary services (ADCS)-E, and cook (C)-A. This had the potential to affect all 64 residents who were served food from the kitchen. Findings include: During an observation and interview on 10/25/21, at 1:00 p.m., with SD-D and during the initial tour of the kitchen, observed a large metal bowl in a walk-up refrigerator. The bowl was covered with plastic wrap and aluminum foil. Handwritten on the foil was "BRN (bran) cookies" and date of "10/13." Inside was dark colored, raw dough. CSD-D stated the dough was for bran cookies	21134	St. Luke's Lutheran Care Center Food Storage Policy states that leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 5 days or discarded. All food items will be checked to assure that foods will be consumed by their "safe used by dates" or discarded. On 10/27/21, the Director of Culinary Services assured that all open containers of refrigerated food were covered, labeled, and dated following facility policy. On an ongoing basis, the Director of Culinary Services or designee will conduct random weekly audits of open containers of refrigerated foods to assure compliance with facility food storage policy. On 10/27/21, the Ecolab representative trained Director of Culinary Services and dietary staff in the use of the 3-compartment sink. On an ongoing basis, the Director of Culinary Services or	12/6/21

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21134	Continued From page 8 and was good for a couple of weeks. Observed multiple jelly roll plans stacked upside down. CSD-D was asked to look at the first few, and the surfaces were noted to be wet. CSD-D directed staff to run them through the dishmachine again. Observed multiple cutting boards stacked vertically, touching one another. CSD-D acknowledged inappropriate storage of pans and cutting boards could create an environment for bacteria to grow. Observed a three-compartment dish washing sink. The monitoring log hanging on a near by cupboard door was blank for the month of October. During an observation on 10/26/21, at 11:00 a.m., the bowl of bran cookie dough in large metal bowl was still in the refrigerator. At the three-compartment sink, an Ecolab Smart Power Sink and Surface Cleaner Sanitizer instructional poster was posted above the sink. Ecolab Sink and Surface Cleaner Sanitizer Test strips with expiration date of 8/2022, were noted on the ledge above the sink. According to Ecolab website, measurements of the chemical sanitizing solution could be taken at any temperature above 65 degrees Fahrenheit. Measurement required a five second dip into the test solution, allowing 10 seconds for the color change to occur, and compare the strip against the color chart on the vial. The required ppm (parts per million) DDBSA (dodecylbenzenesulfonic acid) and ppm lactic acid was outlined by a black box on the color chart. During an interview and observation on 10/26/21, at 11:08 a.m. ADCS-E stated he had no format training for his role, adding he was going to start working on his CDM (certified dietary manager). ADCS-E stated he did not have ServSafe certification as it had expired. When asked what	21134	designee will conduct random weekly audits of completed sanitizer logs and staff setting up and testing sanitation levels in the 3-compartment sink. On 10/27/21, the Director of Culinary Services assured that staff present were re-educated on assuring all pans are completely dried prior to stacking. A commercial cutting board rack was ordered for drying and storage of cutting boards. On an ongoing basis, the Director of Culinary Services or designee will conduct random weekly audits of proper pan and cutting board drying and storage. On 11/30/21, the Director of Culinary Services will hold a mandatory Food Service Training Meeting for all dietary staff that will cover the following topics: 1. Food storage and labeling 2. 3-Compartment Sink training including procedure for monitoring the sanitizing solution 3. Drying and Storage of cutting boards and pans On an ongoing basis, all dietary staff will receive training upon hire on the above topics. Results of the Dietary Department auditing will be summarized by the Director of Culinary Services at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Culinary Services is responsible for overall compliance with this regulation. Completion Date: 11/18/21	

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kind of training he had on the three-compartment sanitizer sink, ADCS-E replied, "Not a whole lot." While standing at the three-compartment sink with ADCS-E and C-A, both stated they had not had training on monitoring and measuring the level of chemical. C-A used a test strip and inserted it in the first sink filled with water and chemical. When asked how long the strip was to be kept in the water, C-A replied "30 seconds." The container of strip container indicated 5 seconds. Then C-A held the strip against the color chart on the vial, but wasn't sure which number to read and record: ppm DDBSA or ppm lactic acid.

During an interview and observation on 10/26/21, at 11:30 a.m., with ADCS-E and C-A at the walk-up refrigerator, C-A was asked to remove the bowl of bran dough. C-A stated they made and served bran cookies on Wednesday and Sunday nights. C-A stated the dough was good for two to three weeks, but but admitted there was nothing that indicated that. C-A obtained the recipe to see if it indicated how long the dough lasted in the refrigerator. It was a hand-written recipe on a card and did not include shelf-life for the raw dough. C-A stated they should probably make smaller batches of dough. At 11:34 a.m., with ADCS-E in walk-in refrigerator, observed a container of Mrs. Gerry's potato salad with approximately one-fourth left. The container did not have a date opened mark on it. ADCS-E stated, "It's not dated; its supposed to be dated," adding if dated, it would be good for five days. A container of Monarch brand salad dressing was observed with approximately one-eight left in the container; the container did not have a date opened mark on it. ADCS-E stated it should have been dated, then discarded after being opened for five days. A large bunch of green onions

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wrapped in plastic were observed with received date of 9/22. ADCS-E did not know if they were still okay to serve residents; he would need to inspect them. ADCS-E stated there wasn't a policy or reference tool that he was aware of for knowing how long produce and opened foods were good for, adding "we say left-overs are good for seven days -- no matter what it is, and 5 days for vendor packaged food like potato salad."

During an interview on 10/27/21, at 9:15 a.m., CSD-D could not recall when training was provided to staff on the three-compartment sink, including monitoring the sanitizing solution. CSD-D admitted she was to be the expert for this process, but did not recall the last time she had training. In addition, CSD-D admitted it was her responsibility to oversee staff to ensure they followed regulations and monitored the effectiveness of the sanitizing solution. CSD-D stated she reminded staff on Monday (10/25/21), to test it. CSD-D was informed that staff had not tested the solution the past two days because they stated did not know how. CSD-D stated the Ecolab representative was scheduled to come today for staff training.

During the same interview, CSD-D stated unopened foods were good until the manufacturer best by or expiration date, and opened foods were good for five days. CSD-D stated staff were to date food when opened, but admitted she did not monitor this. CSD-D was informed of potato salad and salad dressing being opened, but not dated, and of green onions from September. CSD-D stated the potato salad, salad dressing and onions should be discarded. In addition, CSD-D stated she looked up how long the bran cookie dough was good for and learned it was good for a week. CSD-D admitted the dough in

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the refrigerator was 14 days old, would be discarded and smaller batches made going forward. Furthermore, CSD-D could not say, nor provide records that staff had specific training on dating foods when opened, how long foods were good for after opening, letting pans dry before stacking, and not stacking cutting boards.

During an interview on 10/27/21, at 12:22 p.m., the Ecolab representative stated he trained CSD-D and staff how to measure the sanitizing solution in the three-compartment sink. CSD-D provided a list of six staff, plus herself, who received the training.

During an interview on 10/28/21, 13:27 p.m. the administrator stating she was aware of the findings with the three-compartment sink, but not the wet pans, bran dough, and foods not labeled after opening. The administrator stated after findings from the last survey, she didn't expect this, adding she expected staff to be monitoring this and following regulations.

During an observation and interview on 10/28/21, at 10:00 a.m., C-C stated she had training on 10/27, with the Ecolab representative on measuring the sanitizing solution. Observed the three compartment sinks filled with water and solution, but the monitoring log was empty for this date. C-C stated she had been too busy to test the solution. At that point, C-C tested the solution and wrote the information on the log hanging on the cupboard door.

Facility policy titled Cleaning Dishes - Manual Dishwashing, dated 2010, indicated dishes and cookware would be washed after each meal to assure all dishes were clean and sanitary. Check sanitation sink often using a test strip to assure

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the level of sanitation solution is appropriate. Test the sanitizing solution in the sink using the manufacturers suggested test strips to assure appropriate level. Allow dished to air dry. Check all dishes to be sure they are clean and dry prior to storing.

Facility policy titled Food Storage, dated 2010, indicated date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed or discharged, will be visible on all high risk foods. Left-over food is clearly labeled and dated before being refrigerated. Leftover food is used within 5 days or discarded. All food should be labeled and dated. All foods will be checked to assure that foods (including leftovers) are consumed by their safe use dates or discarded.

SUGGESTED METHOD OF CORRECTION:
The dietary director or designee could develop and implement policy and procedure to ensure all staff have been educated and are following regulations and monitoring dishmachine sanitation requirements. Audits could be conducted to ensure compliance and results brought to the quality committee for review. The dietary director or designee could develop and implement policy and procedure to ensure all staff have been educated and are following regulation to ensure dishes and pans are thoroughly dried before stacking/storing. Audits could be conducted to ensure compliance and results brought to the quality committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21375	Continued From page 13	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control measures were maintained for indwelling urinary catheter care for 1 of 1 resident (R43) reviewed for catheter care. Furthermore, the facility failed to ensure hand hygiene was performed during resident care and meal-tray passes for 3 of 3 residents (R43, R54 and R41) observed for infection control practices. Findings include: R43's diagnosis reported printed 10/28/21, included diagnoses of urinary retention, past history of urosepsis (a life threatening complication of an infection caused a urinary tract infection), and urinary tract infection. R43's significant change Minimum Data Set (MDS) assessment dated 9/3/21, indicated R43 was cognitively intact, had adequate hearing and vision, clear speech, was able to make herself understood and could understand others. The MDS further indicated R43 had an indwelling urinary catheter, and required total dependence of one staff for moving about the facility in a wheelchair. R43's physician order dated 7/14/21, indicated	21375	St. Luke's Lutheran Care Center has a well-established infection prevention and control program that includes procedures for hand hygiene and urinary catheter bag care. The facility's Urinary Catheter Use, and Care Guide is written with the goal that residents with an indwelling catheter shall be free from complications of infection. Positioning of the closed urinary drainage system is an essential element of infection prevention. On 10/28/21, a 3M Command Hook was mounted on a bookcase next to R43's recliner for catheter bag placement when the resident is sitting in a recliner. A bungy cord was attached to R43's wheelchair frame under the wheelchair seat to allow positioning of the catheter bag without floor contact. A plan for safe options for catheter bag placement while sitting in a chair or lying in a bed has been made for each resident who has a catheter. On an ongoing basis, the RN Resident Care Coordinator and station nursing staff will develop a plan for safe options for catheter bag placement for each resident with a catheter. On 10/29/21, the Director of Nursing	12/6/21

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	00116	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

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21375	Continued From page 14 indwelling catheter due to urine retention with recurrent urinary tract infections. R43's care plan problem dated 12/14/17, indicated R43 had urinary retention. In addition, a care plan problem dated 12/16/20, indicated there was the potential for overall decline and complications related to history of hospitalization for urinary tract infection with sepsis. During an observation on 10/25/21, at 4:58 p.m., observed R43's urinary drainage bag laying directly on the floor to the right of her recliner. During an observation on 10/25/21, at 5:04 p.m., R43 was observed being transported to the dining room via wheelchair. The bottom of R43's urinary drainage bag which was hooked to the underside of the wheelchair, and was dragged along the floor to the dining room. During an observation on 10/26/21, at 3:25 p.m., R43's urinary drainage bag was observed hooked to the side of her wastebasket which was to the right of her recliner, with the bottom of the bag touching the floor. Hand Hygiene During an observation and interview on 10/25/21, at 4:45 p.m., observed trained medication aide (TMA)-B enter R41's room and set her meal tray on an overbed table. TMA-B woke R41, helped her out of bed, opened the curtains, assisted her to ambulate to the recliner and set up her meal tray. TMA-B exited the room without performing hand hygiene. A hand sanitizer dispenser was observed on the wall near the door. At 4:48 p.m., TMA-B took a meal tray into R54's room and set	21375	posted a memo at each nursing station with instructions that nursing staff read it during shift report through 11/7/21, and sign and date after reading. The memo included re-education on catheter bag care including the facility expectation that a catheter bag should never touch the floor or be attached to a waste basket. The memo also included re-education on hand hygiene including the facility expectation that hand hygiene should occur before, during and after each resident's care was complete. On an ongoing basis, hand hygiene and urinary catheter bag care are included in the orientation checklist for new licensed nurses and nursing assistants. On a weekly basis for one month and then monthly, the Infection Prevention and Control RN or her designee will randomly audit catheter bag care and hand hygiene. Results of auditing will guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee Meeting. After 1 year, the Quality Assessment and Assurance Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation. Completion Date: 12/6/2021	

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21375	Continued From page 15 it on an overbed table. TMA-B helped R54 up from bed, put her shoes on, placing her palm on the bottom of the shoes to get them in place, assisted her into a wheelchair, then to a recliner, then set up her tray. TMA-B exited the room without performing hand hygiene. A hand sanitizer dispenser was observed on the wall near the door. At 4:58 p.m., TMA-B entered R43's room without performing hand hygiene, donned gloves, emptied R43's urinary drainage bag into a urinal. TMA-B emptied the urinal into the toilet, flushed the toilet and removed her gloves. No hand hygiene was performed. TMA-B donned new gloves and helped a nurse with a mechanical lift to transfer R43 into a wheelchair. Once the transfer was complete, with gloved hands, TMA-B opened the curtains, and then removed her gloves. At 5:02 p.m., while standing near the door in R43's room, TMA-B made notations on paper documents, then folded them and tucked them behind R43's hand sanitizer dispenser, performed hand hygiene and exited the room. TMA-B was asked if she cleaned her hands in between resident rooms when delivering meal trays for R41 and R54, and providing care to R43, TMA-B stated she thought she did. When informed it was not observed, TMA-A stated she was sorry, and should have. TMA-B confirmed hand hygiene was important to prevent the spread of germs between residents. During an interview on 10/28/21 at 9:13 a.m., the DON was asked if it was acceptable practice to hang a urinary drainage bag from a wastebasket or lay it directly on the floor and she replied it was not acceptable, adding it was not appropriate due to possible contamination. The DON was informed of the observations of R43's urinary drainage bag secured to the wastebasket in her room, laying on the floor, and being dragged	21375		

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along the floor underneath her wheelchair. The DON stated "that should never happen happen, that's not okay...it shouldn't be on the floor or hanging from the wastebasket." In addition, when informed of observations of lack of hand hygiene between resident cares, the DON stated staff were expected to clean their hands when entering and exiting a residents room to prevent cross contamination, adding they educated staff on that all the time.

During an interview on 10/28/21, at 12:47 p.m., the administrator was informed of findings related to lack of hand hygiene between resident cares, and handling of a urinary drainage bag. The administrator stated she expected staff to perform hand hygiene between residents and acknowledged dispensers were readily available in each resident room, so there was no excuse not to do hand hygiene.

Facility policy titled Policy and Procedure for Hand Hygiene with revised date of 11/2017, indicated the policy was based on CDC guidelines. The policy directed staff to wash hands with soap and water when visibly soiled, and at a minimum before and after each resident contact and after handling any contaminated items. When hands were not visibly soiled, alcohol-based hand rub for decontaminating hands in all other clinical situation. Examples included before and after any resident contact, and before donning gloves.

Facility policy titled Urinary Catheter Use and Care Guide dated 11/2004, indicated the resident with an indwelling catheter shall be free from complications of infection. Hands would be washed before and after performing any procedure for residents with urinary catheters.

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21375	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policy and procedures as needed, educate nursing staff on urinary catheter care, and hand hygiene between care of residents. The DON or designee could conduct ongoing audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 64 residents who reside in the facility and their families. Findings include:	21915	On 11/15/21, the Director of Social Services sent out a letter to each resident's family member/responsible person to provide information regarding the option to participate in a Family Council. Information was included regarding the purpose of a Family Council. A Family Council Interest Survey was	12/6/21

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21915	Continued From page 18 During interview on 10/26/21, at 3:30 p.m., the social worker indicated the facility used to have an active family council, but once Covid-19 became an issue, the newsletters were used to communicate with families. The social worker indicated in the past a survey or letter was sent out and per the documentation was last done in early 2019. The social worker indicated the social services assistant was responsible for family council.. During interview on 10/27/21, at 8:23 a.m. the social services assistant confirmed the last attempt to form a family council was 2019 and indicated the facility had decided to use a communication letter versus family council meetings throughout the Covid-19 pandemic. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure attempts are made to develop a family council. The administrator or her designee could develop monitoring systems to ensure attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	enclosed giving each recipient the option to respond regarding interest in in-person or virtual attendance, or to declined the option of involvement. They were also asked to check if they were interested in facilitating Family Council Meetings. A Family Council meeting has been set for 12/6/21 for those who are interested. On an ongoing basis, information on Family Council will be included in resident admission packets for residents and family member/responsible person. Family Council Meetings will be scheduled on a quarterly basis. The Administrator is responsible for overall compliance with this regulation. Completion Date: 12/06/21	