S

CENTERS FOR MEDICARE & MEDICAID SERVICES

IND HUMAN SERVICES	CENTERS FO
MEDICARE/MEDICAID CERTIFICATIO	N AND TRANSMITTAL
PART I - TO RECOMPLETED BY THE ST	TATE SURVEV AGENCY

ID: LPM8

	PAR	T I - TO BE COMP	PLETED BY 1	HE STAT	TE SURVEY	AGENCY	Fa	cility ID: 00116
1. MEDICARE/MEDICAID I (L1) 245372 2.STATE VENDOR OR MEDI (L2) (L2) 428540900		(L3) ST LUKES (L4) 1219 SOUT	3. NAME AND ADDRESS OF FACILITY (L3) ST LUKES LUTHERAN CARE CENTI (L4) 1219 SOUTH RAMSEY (L5) BLUE EARTH, MN		ER (L6) 56013		 TYPE OF ACTION: Initial Termination Validation 	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHAN (L9)	NGE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEGC 05 HHA	ORY 09 ESRD	<u>02</u> (1 13 PTIP	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
 DATE OF SURVEY ACCREDITATION STATE 0 Unaccredited 2 AOA 	12/14/2021 (L34) US: (L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	:	FISCAL YEAR ENDING 09/30	DATE: (L35)
 11LTC PERIOD OF CERTIF From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	FICATION 79 (L18) 79 (L17)	Compliar 1. B. Not in Co		gram	2. 7 3. 7 4. 7 5. 1	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF Life Safety Code	e Following Requirements: 6. Scope of Servi 7. Medical Direc)8. Patient Room 9. Beds/Room (L12)	ices Limit tor
14. LTC CERTIFIED BED B	PEAKDOWN	Requirements	and/or Applied wa	livers.	* Code: 15. FACILII	A*	(L12)	
	8/19 SNF 19 SN 79	NF ICF	IID			or 1861 (j) (1):	(L15)	
(L37)	(L38) (L39) (L42)	(L43)					
17. SURVEYOR SIGNATUR		Date :	12/30/2021	(110)		survey agency a Poepping, Enfo	APPROVAL	Date: 12/30/2021
	PART II - TO	BE COMPLETED	RV HCFA R	(L19) ECIONAI	OFFICE	DR SINGLE ST	ATE AGENCY	(L20)
19. DETERMINATION OF E 1. Facility is E 2. Facility is E	ELIGIBILITY Eligible to Participate	20. CON RI	MPLIANCE WITH		21. 1	I. Statement of Finan	cial Solvency (HCFA-2572) l Interest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE	23. LTC AGR	EEMENT 2	24. LTC AGREEN	1ENT	26. TERMI	NATION ACTION:	(L	30)
OF PARTICIPATION 12/01/1986	BEGINN	ING DATE	ENDING DAT	Έ	<u>VOLUNTAR</u> 01-Merger, Cl			ARY eet Health/Safety
(L24)	(L41)		(L25)			tion W/ Reimburseme	ent 06-Fail to Me	eet Agreement
25. LTC EXTENSION DAT	A. Susper	ATIVE SANCTIONS nsion of Admissions: I Suspension Date:	(L44)			oluntary Termination	<u>OTHER</u> 07-Provider 5 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:			CADDIED NO		30. REMARK	70		
		29. INTERMEDIARY/	CARRIER NO.		50. KEMAKK	20		
	(L28)	29. INTERMEDIARY/ 03001	CARRIER NO.	(L31)	50. ILLWARE	23		
31. RO RECEIPT OF CMS-1.						INATION APPR	OVAL	



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,

Mighing

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



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,

Mitig

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

	AN SERVICES CARE/MEDICAID CERTIFICATION - TO BE COMPLETED BY THE STA	AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: LPM8 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 CI (L4) 1219 SOUTH RAMSEY (L5) BLUE EARTH, MN	ENTER (L6) 56013	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint

10 NF

11 ICF/IID

12 RHC

14 CORF

16 HOSPICE

____2. Technical Personnel

_____4. 7-Day RN (Rural SNF)

_____ 3. 24 Hour RN

15 ASC

FISCAL YEAR ENDING DATE:

_ 6. Scope of Services Limit

____ 7. Medical Director

____ 8. Patient Room Size

09/30

(L35)

06 PRTF

07 X-Ray

08 OPT/SP

2 AOA3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With From And/Or Approved Waivers Of The Following Requirements: (a): (b) : Program Requirements Compliance Based On: 1. Acceptable POC 12. Total Facility Beds 79 (L18)

02 SNF/NF/Dual

04 SNF

03 SNF/NF/Distinct

13. Total Certified Beds		79 (L18) 79 (L17)	X B. Not in Compl	iance with Program	5. 1	Life Safety Code	9. Beds/Room	
				nd/or Applied Waivers:	* Code:	B *	(L12)	
14. LTC CERTIFIED BE	ED BREAKDOWN	1			15. FACILI	TY MEETS		
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)	
	79							
(L37)	(L38)	(L39)	(L42)	(L43)				

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

10/28/2021

1 TJC

(L34)

(L10)

6. DATE OF SURVEY

0 Unaccredited

То

8. ACCREDITATION STATUS:

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROV	AL Date:
Kari Witte, HFE NE II		12/10/2021 (L19)	Melissa Poepping, Enforcement S	Specialist 12/17/2021 (L20)
P	ART II - TO BE COMP	LETED BY HCFA REGIONA	L OFFICE OR SINGLE STATE A	GENCY
19. DETERMINATION OF ELIGIE 1. Facility is Eligible to 2. Facility is not Eligit	o Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solve Ownership/Control Interest I Both of the Above : 	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE: (L27)	 23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANC A. Suspension of Admis B. Rescind Suspension 	(L44)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
28. TERMINATION DATE:		MEDIARY/CARRIER NO. 001 (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32. DETER (L32)	MINATION OF APPROVAL DATE (L33)	DETERMINATION APPROVAL	



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: 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

St Lukes Lutheran Care Center November 19, 2021 Page 2 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

St Lukes Lutheran Care Center November 19, 2021 Page 3

(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

St Lukes Lutheran Care Center November 19, 2021 Page 4

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 <u>Tamika.Brown@cms.hhs.gov.</u>

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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

St Lukes Lutheran Care Center November 19, 2021 Page 5

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

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		245372	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	000			
	with Appendix Z, Er Requirements, §48 during a standard re facility was NOT in The facility's plan of as your allegation of Department's accept enrolled in ePOC, y	28/21, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The compliance. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567					
E 041 SS=C	onsite revisit of you validate substantial regulation has beer	acceptable electronic POC, an r facility may be conducted to compliance with the n attained. TC Emergency Power	EO	941			12/6/21
	hospital must imple power systems bas forth in paragraph (policies and proced	on for Participation: standby power systems. The ement emergency and standby sed on the emergency plan set a) of this section and in the lures plan set forth in) and (ii) of this section.					
	[LTC facility and the emergency and sta	25(e) standby power systems. The e CAH] must implement ndby power systems based on n set forth in paragraph (a) of					
		3.73(e)(1), §485.625(e)(1) tor location. The generator					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 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.

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	12/10/2021 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G		(X3) DATE COM	E SURVEY PLETED
		245372	B. WING	;				C 28/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE	-	
ST LUK	ES LUTHERAN CARE	CENTER			1219 SOUTH RAMSEY BLUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
E 041	must be located in a requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interin 12-2, TIA 12-3, and when a new structur structure or building 482.15(e)(2), §483. Emergency general [hospital, CAH and the emergency pow and [maintenance] Health Care Facilities Safety Code. 482.15(e)(3), §483. Emergency general LTC facilities] that m to power emergence for how it will keep of operational during t evacuates. *[For hospitals at §4 and CAHs §485.625 The standards inco section are approver reference by the Din Federal Register in 552(a) and 1 CFR p material from the so inspect a copy at th Center, 7500 Secur or at the National A	accordance with the location in the Health Care Facilities d Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA , Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, re is built or when an existing g is renovated. 73(e)(2), §485.625(e)(2) tor inspection and testing. The LTC facility] must implement ver system inspection, testing, requirements found in the es Code, NFPA 110, and Life 73(e)(3), §485.625(e)(3) tor fuel. [Hospitals, CAHs and naintain an onsite fuel source y generators must have a plan emergency power systems he emergency, unless it 482.15(h), LTC at §483.73(g),	E	041				

If continuation sheet Page 2 of 21

		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			СОМ	E SURVEY PLETED
		245372	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST LUKE	S LUTHERAN CARE	CENTER			219 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)			х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 041	202-741-6030, or g http://www.archives _federal_regulation If any changes in th incorporated by refu- document in the Fe- the changes. (1) National Fire Pr Batterymarch Park. Quincy, MA 02169, 1.617.770.3000. (i) NFPA 99, Health edition, issued Aug (ii) Technical interin NFPA 99, issued Aug (iii) TIA 12-3 to NFF (iv) TIA 12-4 to NFF (vi) TIA 12-5 to NFF (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-2 to NFF 2012.	aterial at NARA, call o to: s.gov/federal_register/code_of is/ibr_locations.html. his edition of the Code are erence, CMS will publish a ederal Register to announce otection Association, 1 www.nfpa.org, Care Facilities Code, 2012 ust 11, 2011. n amendment (TIA) 12-2 to ugust 11, 2011. PA 99, issued August 9, 2012. PA 99, issued March 7, 2013. PA 99, issued March 7, 2013. PA 99, issued March 3, 2014. Safety Code, 2012 edition,	E	041			
	2013. (xi) TIA 12-4 to NFF 2013. (xiii) NFPA 110, Sta Standby Power Sys TIAs to chapter 7, i This REQUIREMEN	PA 101, issued October 22, indard for Emergency and stems, 2010 edition, including ssued August 6, 2009 NT is not met as evidenced			On 11/30/21, Interstate Power wi	ll be	
	and staff interview, Emergency Power	the facility failed to test the Supply System per NFPA 99 Ith Care Facilities Code,			completing load-bank testing on t facility's generator. The Building S Director will be responsible for sc	he Services	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		E SURVEY
						C
		245372	B. WING		•	/28/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
ST LUKE	S LUTHERAN CARE	CENTER		219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
E 041	Continued From pa	age 3	E 041			
	(2010 edition), St Standby Power Sy deficient condition	6.4.4.1.3, 6.5.4, and NFPA 110 andard for Emergency and stems, section 8.4.9. This could have a widespread dents within the facility.		the completion of load-bank te least once within every 36 mor The Building Services Director responsible for overall complia this regulation. Completion Date: 12/6/2021	iths. is	
	it was revealed du no documentation confirm that the fac	ween 12:30 p.m. to 3:00 p.m., ring documentation review that was presented for review to cility emergency generator was sted at least once within every				
F 000	verified this deficie discovery.	ne Maintenance Director nt finding at the time of TS	F 000			
F 000	survey was conduct investigation was a was found to be No requirements of 42	28/21. a standard recertification cted at your facility. A complaint also conducted. Your facility OT in compliance with the 2 CFR 483, Subpart B, Long Term Care Facilities.				
	SUBSTANTIATED	77129) 66083) 61812) 67603)				

If continuation sheet Page 4 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245372	B. WING				C 28/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000 F 688 SS=D	UNSUBSTANTIATE H5372034C (MN67 (MN68195). The facility's plan or as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an onsite revisit of you validate that substar regulations has beet Increase/Prevent D CFR(s): 483.25(c)(1) §483.25(c) Mobility §483.25(c)(1) The f resident who enters range of motion door range of motion und condition demonstr- of motion is unavoid §483.25(c)(2) A ress motion receives appropriat assistance to maint the maximum pract reduction in mobility	ED: H5372035C (MN64739), 147) and H5372039C f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. ecrease in ROM/Mobility 1)-(3) facility must ensure that a s the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range		5888			12/6/21

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		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245372	B. WING	i			C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
STILIKE	S LUTHERAN CARE	CENTER		1	1219 SOUTH RAMSEY		
01 2010		o Entrenk		E	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	-	ge 5	F6	688			
	review the facility fa motion program for completed for 1 of 2 with limited range of Findings include: R12's face sheet, p admission date of 7 diagnoses of parap your trunk, and legs filled blisters betwee backbone), obesity damage). R12's admission M assessment dated intact cognition, lim lower extremities at 2 or more persons bathing. R12's Range of Mo Assessment dated indicated R12 had ADL's, is non-ambu and active range of complete upper ran assistance with low paraplegic, has ser body, is unable to a significant range of joints are stiff. R12's care plan dat an alteration in active	tion, interview and document illed to ensure a range of lower extremities was 2 residents (R12) reviewed f motion. rinted 10/27/21, indicated an 7/16/21 and identified legia (paralysis of all or part of s), intraspinal abscess (pus en the spinal cord and , and polyneuropathy (nerve inimum Data Set (MDS) 7/22/21, identified R12 had ited range of motion of both nd required extensive assist of for transfers, bed mobility and tion Observation and 7/22/21, and 10/20/21, very limited ability to perform alatory, and requires passive motion. R12 is able to age of motion but requires er extremity as R12 is asation of pressure to lower imbulate and has no motion restrictions noted but			St. Luke's Lutheran Care Center committed to providing a range of program to improve or maintain re joint mobility and muscle strength though the nursing assistant Resi Assignment sheet stated that R12 receive range of motion exercises with am cares, the nursing assista did not consistently provide the ex- as directed. A copy of the range of motion exer- developed by the Therapy Depart was in the comprehensive care pl binder. A copy has been placed in In-Room Care Plan folder in the re- bathroom; an approach for ROM exercises is also written in R12's comprehensive care plan. To assure that R12 and other resi receive range of motion exercises directed, the station charge nurse designee will be responsible for c with the resident and nursing assi see if the nursing assistant perfor range of motion exercises as dire The RN Resident Care Coordinat charge nurse will be responsible for carge nurse will be responsible for comprehensive care plan. To assure that R12 and other resi receive range of motion exercises directed, the station charge nurse designee will be responsible for c with the resident and nursing assist see if the nursing assistant perfor range of motion exercises as dire The RN Resident Care Coordinat charge nurse will be responsible for com this verification in the re- electronic health record for the stat charge nurse to verify completion exercises scheduled during their document this verification and treatmer record. The charge nurse verificat documentation step has been add the facility's Range of Motion Pro- On 10/27/21, the Director of Nurs posted a memo at each nursing s	i motion esidents' . Even dent 2 was to a daily ant staff cercises rcises ment an 0 R12's esident's dents a as or hecking stant to med cted. or or or sident's ation of shift and esident's ent tion and ded to cedure. sing	

Facility ID: 00116

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		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED
		245372	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/2	-0/2021
ST LUKE	S LUTHERAN CARE	CENTER		1: B			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	and lower body. The restorative or range A physician dischart therapist on 7/28/22 indicated the reside nursing to complete motion program. Point of Care range sheet indicated ran completed five times September, and see During interview on indicated he has pathis lower half of his move his legs some demonstrated minine extremities and was mattress. R12 furth therapy on his legs and staff have not of his legs since therapist (If therapy upon admised ischarge a range of prescribed for his legs and staff or his legs are and staff or his legs are and staff or his legs and staff or his legs are and staff or his legs and staff or his legs are	t with washing and drying back he care plan did not include a e of motion program. ge order dated signed by the 1, and the physician on 8/7/21, ent will be discharged with the the lower extremity range of e of motion documentation ge of motion once a day was es in August, eight times in ven times in October, 2021. 10/25/21, at 2:34 p.m., R12 aralysis with loss of feeling in body. R12 indicated he can e, but not his feet. R12 mal movement of both lower s unable to lift his legs off the er indicated he has not had since he came to the facility completed range of motion on	F	588	with instructions that nursing staff during shift report through 11/7/21 sign and date after reading. The m discussed the importance of comp range of motion exercises at the frequency specified in the care pla well as importance of NA documen of completion in Matrix Care Assis memo instructed charge nurses to with the nursing assistant and resi verify completion of exercises and document completion in EMAR. The facility's Range of Motion Exe Procedure is included in the Licen Nurse Orientation Checklist and N Assistant Orientation Checklist for Nursing Department employees. On a weekly basis for one month a monthly, the Director of Nursing of designee will randomly audit documentation of verification of Re cares by nursing assistant staff in Care Assist and documentation of verification of ROM cares in reside EMAR. On a monthly basis, the St Development RN or her designee randomly audit completion of rang motion exercises during nursing a care audits. Results of auditing wil future compliance monitoring and In addition, the results will be sum at the quarterly Quality Assessment	, and hemo oletion of in, as ntation t. The o check dent to rcise sed ursing all new and then cher OM Matrix nurse ents' aff will e of ssistant I guide training. marized	
	pictures and and lis PT stated R12 is no extremity range of r During interview on registered nurse (R	ated how often to complete with ot capable of doing the lower motion without assistance. 10/27/21, at 9:26 a.m., N)-A indicated the range of s program was listed on the			Assurance Committee Meeting. A year, the Quality Assessment and Assurance Committee will re-evalu- need and frequency for continued compliance monitoring. The Director of Nursing is respons overall compliance with this regula	fter 1 uate the sible for	

Facility ID: 00116

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		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245372	B. WING				C 28/2021
NAME OF F	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ige 7	F	688			
		r the nursing assistants to not completed daily.			Completion Date: 12/6/21		
	nursing assistant (N	10/27/21, at 9:34 a.m., NA)-A indicated she was ved range of motion exercises.					
	indicated she was u motion exercises in nursing assistant ca	10/27/21, at 9:36 a.m., NA-B unsure if R12 required range of hitially but after looking at the are sheet, NA-B stated it is every a.m. while in bed.					
		10/27/21, at 9:44 a.m., R12 ot had any range of motion /25/21.					
	RN-B indicated ger instructions from th bathroom, but R12 RN-B did locate the communication bind included instruction exercises to be com	der at the nurses station that is for range of motion npleted for 5 exercises with hand written note stating					
	director of nursing of wasn't completed d The DON was able the communication	10/28/21, at 8:42 a.m., the confirmed the range of motion laily and it should have been. to locate the instructions in book but indicated it should n the bathroom but was not.					
	Motion" undated, in - The purpose is to	procedure titled "Range of acluded: move the resident's joints nge of motion as possible, to					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	. 0938-039 E SURVEY IPLETED
		245372	B. WING		10	C / 28/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	20/2021
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 688	strength, prevent or and activity tolerand complications of im -General resident of guidelines included problem under whice approach	n joint mobility and muscle ontractures, increase strength ce, reduce pain and prevent imobility. are plan documentation identify the appropriate ch to list range of motion as an itled "Procedure: Range of	F 68	8		
	 A range of motion on each resident up annually and signifi The therapy depa screen residents if to joint mobility. The resident or hi contacted if therapy evaluation. If approvide will be contacted an evaluation will be mean of the therapy recommendation 	assessment will be completed oon admission, quarterly, cant change. rtment will be contacted to indicated for concerns related s/her responsible party will be y staff recommends an oved, the resident's physician nd a request for a therapy nade. endations for range of motion obility maintenance program a resident care plan. Store/Prepare/Serve-Sanitary	F 81	2		12/6/21
	§483.60(i) Food sa The facility must - §483.60(i)(1) - Proc approved or consid state or local autho (i) This may include from local produced and local laws or re	fety requirements. cure food from sources lered satisfactory by federal, rities. a food items obtained directly rs, subject to applicable State				

Facility ID: 00116

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		& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
					С
		245372	B. WING _		10/28/2021
NAME OF F	PROVIDER OR SUPPLIER	•	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP C	ODE
STILIKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY	
SILUKE	S LUTHERAN CARE	GENTER		BLUE EARTH, MN 56013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 812	Continued From pa	ace 9	F 81	2	
		produce grown in facility	1 01	2	
		compliance with applicable			
		pod-handling practices.			
	(iii) This provision of	loes not preclude residents			
	from consuming for	ods not procured by the facility.			
		e, prepare, distribute and dance with professional			
	standards for food				
		NT is not met as evidenced			
	by:				
		tion, interview, and document		St. Luke's Lutheran Care C	enter Food
		ailed to ensure dishwashing		Storage Policy states that le	
		1 dishmachine was		stored in covered containers	
		ored. In addition, the facility opened containers of food in 1		carefully and securely. Each clearly labeled and dated be	
		rator, and to ensure pans were		refrigerated. All food items v	
		bre storing. Furthermore, the		to assure that foods will be	
		ure dietary staff received		their "safe used by dates" or	
		an on-going basis for 3 of 3		On 10/27/21, the Director of	f Culinary
		ces director (SD)-D, assistant		Services assured that all op	
		services (ADCS)-E, and cook		of refrigerated food were co	
		potential to affect all 64 e served food from the kitchen.		labeled, and dated following	
	residents who were	served lood from the kitchen.		On an ongoing basis, the Di Culinary Services or design	
	Findings include:			random weekly audits of op of refrigerated foods to assu	en containers
	During an observat	ion and interview on 10/25/21,		with facility food storage pol	
		D-D and during the initial tour		On 10/27/21, the Ecolab rep	
	of the kitchen, obse	erved a large metal bowl in a		trained Director of Culinary	
		r. The bowl was covered with		dietary staff in the use of the	
		uminum foil. Handwritten on		3-compartment sink. On an	
		bran) cookies" and date of		basis, the Director of Culina	
		dark colored, raw dough. dough was for bran cookies		designee will conduct rando audits of completed sanitize	
		couple of weeks. Observed		staff setting up and testing s	
		ans stacked upside down.		levels in the 3-compartment	
		to look at the first few, and the		On 10/27/21, the Director of	
	aurfaces were note	d to be wet. CSD-D directed		Services assured that staff	

Facility ID: 00116

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY	
			A. BUILDIN B. WING	NG		С	
		245372	B. WING _			28/2021	
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, 1219 SOUTH RAMSEY BLUE EARTH, MN 56013	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE	
F 812	Observed multiple vertically, touching acknowledged inap cutting boards coul bacteria to grow. O dish washing sink. a near by cupboard of October. During an observat the bowl of bran co was still in the refrig three-compartment Sink and Surface O poster was posted and Surface Clean expiration date of 8 ledge above the sin website, measuren solution could be ta 65 degrees Fahren five second dip into seconds for the col compare the strip a vial. The required p	rough the dishmachine again. cutting boards stacked one another. CSD-D propriate storage of pans and d create an environment for bserved a three-compartment The monitoring log hanging on d door was blank for the month d door was blank for the month tion on 10/26/21, at 11:00 a.m., okie dough in large metal bowl gerator. At the t sink, an Ecolab Smart Power Cleaner Sanitizer instructional above the sink. Ecolab Sink er Sanitizer Test strips with 6/2022, were noted on the hk. According to Ecolab nents of the chemical sanitizing aken at any temperature above theit. Measurement required a the test solution, allowing 10 or change to occur, and against the color chart on the opm (parts per million) DDBSA ulfonic acid) and ppm lactic	F 81	12 re-educated on assurin completely dried prior to commercial cutting boar ordered for drying and s boards. On an ongoing of Culinary Services or conduct random weekly pan and cutting board of On 11/30/21, the Direct Services will hold a ma Service Training Meetir staff that will cover the 1. Food storage and la 2. 3-Compartment Sir including procedure for sanitizing solution 3. Drying and Storage and pans On an ongoing basis, a receive training upon hi topics. Results of the Dietary D auditing will be summal Director of Culinary Ser quarterly Quality Asses Assurance Committee year, the Quality Asses Assurance Committee	o stacking. A ird rack was storage of cutting basis, the Director designee will y audits of proper drying and storage. tor of Culinary ndatory Food ng for all dietary following topics: abeling nk training monitoring the e of cutting boards Il dietary staff will ire on the above Department rized by the rvices at the sment and Meeting. After 1 sment and		
	chart. During an interview at 11:08 a.m. ADCS training for his role, working on his CDI ADCS-E stated he certification as it ha kind of training he I sanitizer sink, ADC	y a black box on the color y and observation on 10/26/21, S-E stated he had no format , adding he was going to start M (certified dietary manager). did not have ServSafe ad expired. When asked what had on the three-compartment S-E replied, "Not a whole lot." he three-compartment sink		need and frequency for compliance monitoring. The Director of Culinary responsible for overall of this regulation. Completion Date: 12/6/	continued y Services is compliance with		

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		ONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245372	B. WING			10	C / 28/2021	
	PROVIDER OR SUPPLIER	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013			-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 812	had training on mo level of chemical. (inserted it in the first chemical. When as be kept in the water The container of st seconds. Then C-A color chart on the wall number to read an lactic acid. During an interview at 11:30 a.m., with walk-up refrigerator the bowl of bran do and served bran co Sunday nights. C-A for two to three we was nothing that in recipe to see if it in lasted in the refriger recipe on a card ar the raw dough. C-A make smaller batc with ADCS-E in wa container of Mrs. C approximately one- not have a date op stated, "It's not dat adding if dated, it w container; the cont opened mark on it. been dated, then d for five days. A larg wrapped in plastic	age 11 C-A, both stated they had not nitoring and measuring the C-A used a test strip and st sink filled with water and sked how long the strip was to er, C-A replied "30 seconds." rip container indicated 5 A held the strip against the vial, but wasn't sure which d record: ppm DDBSA or ppm v and observation on 10/26/21, ADCS-E and C-A at the r, C-A was asked to remove ough. C-A stated they made ookies on Wednesday and A stated the dough was good eks, but but admitted there dicated that. C-A obtained the idicated how long the dough erator. It was a hand-written nd did not include shelf-life for A stated they should probably hes of dough. At 11:34 a.m., ilk-in refrigerator, observed a Gerry's potato salad with -fourth left. The container did ened mark on it. ADCS-E ed; its supposed to be dated," vould be good for five days. A rch brand salad dressing was roximately one-eight left in the ainer did not have a date ADCS-E stated it should have iscarded after being opened ge bunch of green onions were observed with received S-E did not know if they were	F 8	12				

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		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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ST LUK	ES LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	still okay to serve re- inspect them. ADC3 policy or reference knowing how long p were good for, addi for seven days no for vendor package During an interview CSD-D could not re- provided to staff on including monitoring CSD-D admitted sh process, but did no training. In addition responsibility to ove followed regulations effectiveness of the stated she reminde to test it. CSD-D wa tested the solution they stated did not Ecolab representati today for staff traini During the same in- unopened foods we best by or expiration were good for five of to date food when on not monitor this. CS salad and salad dre dated, and of green CSD-D stated the p and onions should CSD-D stated she I cookie dough was g good for a week. C	esidents; he would need to S-E stated there wasn't a tool that he was aware of for produce and opened foods ing "we say left-overs are good o matter what it is, and 5 days of food like potato salad." on 10/27/21, at 9:15 a.m., ecall when training was the three-compartment sink, g the sanitizing solution. He was to be the expert for this t recall the last time she had , CSD-D admitted it was her ersee staff to ensure they is and monitored the e sanitizing solution. CSD-D d staff on Monday (10/25/21), as informed that staff had not the past two days because know how. CSD-D stated the ive was scheduled to come	F	312			

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		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	discarded and sma forward. Furthermo provide records that dating foods when of good for after open stacking, and not sta During an interview the Ecolab represent CSD-D and staff ho solution in the three provided a list of six received the training During an interview administrator stating findings with the thr the wet pans, bran after opening. The a findings from the la this, adding she exp this and following re During an observati at 10:00 a.m., C-C 10/27, with the Eco measuring the sani three compartment solution, but the mo date. C-C stated sh the solution. At that and wrote the inforr the cupboard door. Facility policy titled Dishwashing, dated cookware would be	ller batches made going ore, CSD-D could not say, nor at staff had specific training on opened, how long foods were ing, letting pans dry before tacking cutting boards. on 10/27/21, at 12:22 p.m., ntative stated he trained ow to measure the sanitizing e-compartment sink. CSD-D x staff, plus herself, who g. on 10/28/21, 13:27 p.m. the g she was aware of the ree-compartment sink, but not dough, and foods not labeled administrator stated after ist survey, she didn't expect pected staff to be monitoring egulations. ion and interview on 10/28/21, stated she had training on lab representative on tizing solution. Observed the sinks filled with water and onitoring log was empty for this he had been too busy to test t point, C-C tested the solution mation on the log hanging on	F	312	DEFICIENCY)		
	Dishwashing, dated cookware would be assure all dishes w	d 2010, indicated dishes and					

If continuation sheet Page 14 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245372	B. WING	 		C 28/2021
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER		219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812 F 880 SS=E	the level of sanitation the sanitizing solution manufacturers sugg appropriate level. A all dishes to be sure to storing. Facility policy titled indicated date mark by which a ready-to food should be con- visible on all high ris clearly labeled and refrigerated. Leftow or discarded. All food dated. All foods will foods (including left safe use dates or d Infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investigat	Test on in the sink using the gested test strips to assure llow dished to air dry. Check e they are clean and dry prior Food Storage, dated 2010, sing to indicate the date or day -eat, potentially hazardous sumed or discharged, will be sk foods. Left-over food is dated before being er food is used within 5 days od should be labeled and be checked to assure that covers) are consumed by their iscarded. n & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program e a safe, sanitary and ment and to help prevent the ansmission of communicable ions. n prevention and control tablish an infection prevention and control revention and control tablish and maintain an or and control tablish and maintain an and control tablish and maintain an and control program e a safe, sanitary and ment and to help prevent the ansmission of communicable ions.	F8			12/6/21

If continuation sheet Page 15 of 21

		AND HUMAN SERVICES				FORM	12/10/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245372	B. WING	i			C 28/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	ES LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the but are not limited t (i) A system of surv possible communic infections before the persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre (iv)When and how if resident; including b (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos circumstances. (v) The circumstance must prohibit emplot disease or infected contact with resider contact with resider by staff involved in the §483.80(a)(4) A system involved and the system involved in the system involved in the system involved in the system involved in the system contact with resider contact with resider contact with resider contact with resider involved in the system involved in the system invol	sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, to: reillance designed to identify table diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility by es with a communicable skin lesions from direct it the disease; and ne procedures to be followed direct resident contact.	F	880			

		AND HUMAN SERVICES				FORM	12/10/202 ⁻ APPROVEI <u>0938-039</u> -
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			COM	E SURVEY PLETED
		245372	B. WING			(10/2	_ 28/2021
NAME OF F	PROVIDER OR SUPPLIER	·	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	transport linens so infection. §483.80(f) Annual of The facility will com IPCP and update th This REQUIREME by: Based on observa review, the facility f control measures v urinary catheter can reviewed for cathet facility failed to ens performed during re passes for 3 of 3 re observed for infect Findings include: R43's diagnosis rep included diagnoses history of urosepsis complication of an infection), and urina R43's significant cf (MDS) assessment was cognitively inta vision, clear speect understood and co	ndle, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview and document failed to ensure infection vere maintained for indwelling re for 1 of 1 resident (R43) ther care. Furthermore, the ure hand hygiene was esident care and meal-tray esidents (R43, R54 and R41) ion control practices.	F 8	80	St. Luke s Lutheran Care Center h well-established infection preventior control program that includes proce for hand hygiene and urinary catheter care. The facility s Urinary Catheter Use, Care Guide is written with the goal t residents with an indwelling catheter be free from complications of infecti Positioning of the closed urinary dra system is an essential element of in prevention. On 10/28/21, a 3M Command Hook mounted on a bookcase next to R43 recliner for catheter bag placement the resident is sitting in a recliner. A cord was attached to R43 s wheeld frame under the wheelchair seat to a positioning of the catheter bag witho floor contact. A plan for safe options catheter bag placement while sitting chair or lying in a bed has been made each resident who has a catheter. C	n and dures er bag , and hat r shall on. inage fection was 3 s when bungy chair allow but s for j in a de for On an	
	urinary catheter, ar of one staff for mov wheelchair.	ted R43 had an indwelling nd required total dependence ving about the facility in a der dated 7/14/21, indicated			ongoing basis, the RN Resident Car Coordinator and station nursing staf develop a plan for safe options for catheter bag placement for each res with a catheter. On 10/29/21, the Director of Nursing	f will sident	

Facility ID: 00116

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	- OUNLOTION	DENTITION NOMBER.	A. BUILDIN	G		C
		245372	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 17	F 88	0		
	· ·	due to urine retention with		posted a memo at each nursing with instructions that nursing sta during shift report through 11/7/2	ff read it	
	R43's care plan problem dated 12/14/17, indicated R43 had urinary retention. In addition, care plan problem dated 12/16/20, indicated the		sign and date after reading. The included re-education on cathete care including the facility expect	memo er bag		
	was the potential for	or overall decline and ed to history of hospitalization	a catheter bag should never touchhistory of hospitalizationfloor or be attached to a waste bewith sepsis.The memo also included re-educen 10/25/21, at 4:58 p.m.,e right of her recliner.a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or be attached to a waste ben a catheter bag should never touchfloor or ben a catheter bag should never touch <td>ch the asket. cation on</td> <td></td>	ch the asket. cation on		
	observed R43's uri	ion on 10/25/21, at 4:58 p.m., nary drainage bag laying to the right of her recliner.		expectation that hand hygiene s occur before, during and after ea resident s care was complete.	nould ach	
	R43 was observed room via wheelcha drainage bag which	tion on 10/25/21, at 5:04 p.m., being transported to the dining ir. The bottom of R43's urinary n was hooked to the underside and was dragged along the oom.		On an ongoing basis, hand hygi urinary catheter bag care are ind the orientation checklist for new nurses and nursing assistants. On a weekly basis for one mont monthly, the Infection Prevention Control RN or her designee will	d hygiene and are included in r new licensed ants. month and then vention and	
	R43's urinary drain to the side of her w	tion on 10/26/21, at 3:25 p.m., age bag was observed hooked rastebasket which was to the , with the bottom of the bag		audit catheter bag care and han Results of auditing will guide futu compliance monitoring and train addition, the results will be sum the quarterly Quality Assessmer Assurance Committee Meeting. year, the Quality Assessment an Assurance Committee will re-ev	ure ing. In narized at t and After 1 d	
	Hand Hygiene			need and frequency for continue compliance monitoring.	d	
	at 4:45 p.m., obser (TMA)-B enter R41	ion and interview on 10/25/21, ved trained medication aide 's room and set her meal tray e. TMA-B woke R41, helped		The Director of Nursing is respo overall compliance with this regu Completion Date: 12/6/2021		
	her out of bed, ope to ambulate to the tray. TMA-B exited hand hygiene. A ha	ned the curtains, assisted her recliner and set up her meal the room without performing and sanitizer dispenser was all near the door. At 4:48 p.m.,		Please see the attachments for Control	Infection	

Facility ID: 00116

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STATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION). 0938-039 TE SURVEY
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	G	COMPLETED	
245372		B. WING		C 10/28/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 880	• · · · · · · · · · · · · · · · · · · ·	-	F 88	0		
	it on an overbed tal from bed, put her s the bottom of the s assisted her into a then set up her tray without performing sanitizer dispenser the door. At 4:58 p. room without perfor gloves, emptied R4 urinal. TMA-B emp flushed the toilet ar hand hygiene was new gloves and he lift to transfer R43 i transfer was compl opened the curtains gloves. At 5:02 p.m in R43's room, TM/ documents, then for behind R43's hand	I tray into R54's room and set ble. TMA-B helped R54 up hoes on, placing her palm on hoes to get them in place, wheelchair, then to a recliner, /. TMA-B exited the room hand hygiene. A hand was observed on the wall near m., TMA-B entered R43's rming hand hygiene, donned Id's's urinary drainage bag into a tied the urinal into the toilet, nd removed her gloves. No performed. TMA-B donned lped a nurse with a mechanical nto a wheelchair. Once the ete, with gloved hands, TMA-B s, and then removed her I., while standing near the door A-B made notations on paper olded them and tucked them sanitizer dispenser, performed exited the room. TMA-B was				
	asked if she cleaner resident rooms whe R41 and R54, and stated she thought not observed, TMA should have. TMA- important to prever between residents. During an interview DON was asked if hang a urinary drai or lay it directly on not acceptable, add to possible contam	ed her hands in between en delivering meal trays for providing care to R43, TMA-B she did. When informed it was A stated she was sorry, and B confirmed hand hygiene was at the spread of germs				

If continuation sheet Page 19 of 21

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245372 B. WING					C 28/2021	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY		
				E	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 880	Continued From pa drainage bag secur room, laying on the along the floor unde DON stated "that sh that's not okayit s hanging from the w informed of observa between resident ca were expected to cl and exiting a reside contamination, addi all the time. During an interview the administrator wa to lack of hand hygi and handling of a u administrator stated perform hand hygie acknowledged disp in each resident roo not to do hand hygie Facility policy titled Hand Hygiene with indicated the policy guidelines. The poli hands with soap an and at a minimum b contact and after ha items. When hands alcohol-based hand hands in all other cl	age 19 red to the wastebasket in her floor, and being dragged erneath her wheelchair. The hould never happen happen, houldn't be on the floor or rastebasket." In addition, when ations of lack of hand hygiene ares, the DON stated staff lean their hands when entering ents room to prevent cross ing they educated staff on that on 10/28/21, at 12:47 p.m., as informed of findings related iene between resident cares, rinary drainage bag. The d she expected staff to ene between residents and ensers were readily available om, so there was no excuse ene. Policy and Procedure for revised date of 11/2017, was based on CDC icy directed staff to wash ad water when visibly soiled, before and after each resident andling any contaminated is were not visibly soiled, d rub for decontaminating linical situation. Examples d after any resident contact,	F 8		DEFICIENCY)	<pre>NATE</pre>	DATE
	Facility policy titled Care Guide dated 1	Urinary Catheter Use and 11/2004, indicated the resident atheter shall be free from					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM A	12/10/2021 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245372	B. WING				8/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD I D THE APPROPR	BE	(X5) COMPLETION DATE
F 880	washed before and	age 20 fection. Hands would be l after performing any ents with urinary catheters.	F8	380			

Facility ID: 00116

		AND HUMAN SERVICES	-53720)32	<u></u>	FORM	12/09/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245372	B. WING			10/	26/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			1219 SOUTH RAMSEY		
				-	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 0	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 10/26/2021. At the LUKES LUTHERAM not in compliance w participation in Med Subpart 483.70(a), 2012 edition of NEPA) Chapter 19 Existing edition of NFPA 99, THE FACILITY'S Per ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically 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.

		AND HUMAN SERVICES				FORM	12/09/2021 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	0938-0391
AND PLAN O	FORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	01 - MAIN BUILDING 01	COMPLETED	
		245372	B. WING			10/:	26/2021
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
K 000	Continued From pa	ae 1	КC	000			
	Healthcare Fire Ins	•		,00			
	State Fire Marshal	Division					
	445 Minnesota St., St. Paul, MN 55101						
	By email to:						
	FM.HC.Inspections	@state.mn.us					
		RRECTION FOR EACH					
	FOLLOWING INFC	T INCLUDE ALL OF THE DRMATION:					
		ription of the corrective action correct the deficiency.					
		easures that will be put in deficiency does not reoccur.					
		e facility plans to monitor to ensure solutions are					
	4. Identify who is r actions and monitor	responsible for the corrective ring of compliance.					
	5. The actual or p the remedy.	roposed date for completion of					
	ST LUKES LUTHEI story building with p	RAN CARE CENTER is a 1 partial basement.					
	one-story in height, was determined to construction. In 19 constructed, one-st basement, and was	69 an addition was ory in height with no determined to be of Type II					
	(111) construction.	In 1975 an addition was					

If continuation sheet Page 2 of 13

		AND HUMAN SERVICES				FORM	12/09/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245372	B. WING			10/	26/2021
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY		
SILUKE	S LUTHERAN CARE	CENTER		E	BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	basement, and was (111) construction. constructed, one-st basement, and was (111) construction. building addition wa height with no base be of Type II (111) of Because the origina compatible constru- buildings of this hei as one building as National Fire Protect Standard 101, Life 19 Existing Health of The facility is fully p automatic sprinkler system with smoke corridors and space monitored for autor notification.	tory in height with no s determined to be of Type II In 2005 an addition was tory in height with no s determined to be of Type V In 2008 an mechanical as constructed, one-story in ement, and was determined to construction. al building and additions are ction types allowed for existing ght, the facility was surveyed allowed in the 2012 edition of ction Association (NFPA) Safety Code (LSC), Chapter Care Occupancies. orotected throughout by an system and has a fire alarm detection in resident rooms, es open to the corridors that is natic fire department	ΚO	000			
	census of 63 at the	42 CFR, Subpart 483.70(a) is	К 3	24			12/6/21
	with NFPA 96, Stan	t is protected in accordance dard for Ventilation Control of Commercial Cooking					

Facility ID: 00116

If continuation sheet Page 3 of 13

		AND HUMAN SERVICES				FORM	12/09/202 APPROVE <u>0938-039</u>
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245372	B. WING			10/2	26/2021
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKES LUTHERAN CARE CENTER					219 SOUTH RAMSEY LUE EARTH, MN 56013		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 324	Continued From pa	age 3	К 3	24			
		g equipment (i.e., small					
	appliances such as	microwaves, hot plates,					
		for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2					
		open to the corridor in smoke					
	compartments with	30 or fewer patients comply					
	with the conditions or	under 18.3.2.5.3, 19.3.2.5.3,					
	* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under						
	18.3.2.5.4, 19.3.2.5	5.4. rotected according to NFPA 96					
		equired to be enclosed as					
		out shall not be open to the					
	corridor.	18.3.2.5.4, 19.3.2.5.1 through					
	19.3.2.5.5, 9.2.3, T						
		NT is not met as evidenced					
	by: Based on a review	v of available documentation			Arrangements have been made for		
	and staff interview,	the facility failed to maintain			Fairmont Fire Systems to come to S	St.	
		extinguishing equipment in			Luke's Lutheran Care Center during		
		e NFPA 101 (2012 edition), sections 19.3.2.5, 9.2.3, and			week of 11/29/21 to conduct Hydros testing of the facility's Ansul type fire		
	19.3.2.5.3(10), NFI	PA 96 (2011 edition), Standard			suppression system. Hydrostatic te	sting	
		trol and Fire Protection of			is to occur on a 12-year cycle. On a		
		ng Operations, section 10.2.6,)09 edition), Standard for Wet			ongoing basis, the Building Services Director will be responsible for assu		
	Chemical Extinguis	shing Systems, section 7.5.1.			that testing occurs within the 12-year		
		ng could have an isolated			testing cycle.		
		lents within the facility.			The Director of Building Services is responsible for overall compliance v	with	
	Findings Include:				this regulation. Completion Date: 12/6/2021		
	On 10/26/2021 bet	ween 12:30 PM to 03:00 PM, it			-		

Facility ID: 00116

If continuation sheet Page 4 of 13

		AND HUMAN SERVICES			FORM	: 12/09/2021 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245372	B. WING _		10/	26/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 324	Continued From pa	ge 4	K 32	24		
		g a review of available the last hydrostatic test of the				
	Ansul type fire supp 2005. Hydrostatic f	pression system occurred in testing is to occur on a 12-year system should have been				
		e Maintenance Director nt finding at the time of				
	Sprinkler System - CFR(s): NFPA 101	Maintenance and Testing	K 35	53		12/6/21
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available.	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire s. Records of system design, action and testing are cure location and readily system last checked				
	b) Who provided s	system test				
	c) Water system s	supply source				
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN	KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced				
	facility failed to insp system in accordar	tion and staff interview, the bect and maintain the sprinkler ice with NFPA 101 (2012 Code, sections 9.7.5, 9.7.6,		On 11/11/21, sprinkler heads the exhibited signs of oxidation were replaced. On 11/24/21, items th noted to be placed closer than e	e at were	

Facility ID: 00116

If continuation sheet Page 5 of 13

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245372	B. WING _		10/	26/2021
NAME OF I	PROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP COL		
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	and NFPA 25 (2011 Inspection, Testing, Water-Based Fire F 5.2, 5.2.1.1.1, 5.2.1 5.2.2.2. NFPA 13 (2 Installation of Sprin 8.5.6.1. This deficie widespread impact facility. Findings include: 1. On 10/26/2021 b PM, it was revealed Kitchen dish-washi Room B205 that sp of oxidation 2. On 10/26/2021 b PM, it was revealed were placed closer sprinkler head(s) in Volunteer Services A326, M714, M704 D123, D115, M032 An interview with th verified these defic discovery. Subdivision of Build CFR(s): NFPA 101 Subdivision of Build Doors 2012 EXISTING Doors in smoke ba bonded wood-core	etween 10:00 AM to 12:30 d by observation that in the ng area, the Dining Area, and orinkler heads exhibited signs	K 35	inches to the facility sprinkler re-located to assure the require space between items and sprint The Building Services Directore designee will conduct random audits within the facility to ass compliance with the 18-inch s requirement between items at heads. Results of auditing will summarized at the quarterly of Assessment and Assurance of Weeting. After 1 year, the Quart Assessment and Assurance of will re-evaluate the need and the for continued compliance mor The Director of Building Servit responsible for overall compliant this regulation. Completion Date: 12/6/2021	red 18-inch nkler heads. r or his monthly ure pace nd sprinkler I be Quality Committee frequency hitoring. ces is	12/6/21

If continuation sheet Page 6 of 13

		AND HUMAN SERVICES				FORM	12/09/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION () 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245372	B. WING			10/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 374 K 511 SS=E	are permitted to ha assemblies per 8.5 automatic-closing, a are not required to egress travel. Door clear width of 32 ind doors. 19.3.7.6, 19.3.7.8, This REQUIREMEN by: Based on observat facility failed to insp inspect the smoke (2012 edition), Life and 8.5.4.1. This de widespread impact facility. Findings include: On 10/26/2021 betw was revealed by ob barrier doors of Blu door set identified a vertical air-gaps gre inch. An interview with th verified this deficier discovery. Utilities - Gas and E CFR(s): NFPA 101	height are permitted. Doors ve fixed fire window . Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 NT is not met as evidenced tion and staff interview, the bect and maintain, test, and barrier doors per NFPA 101 Safety Code, sections 19.3.7 eficient condition could have a on the residents within the ween 10:00 AM to 12:30 PM, it servation that the smoke ebird Wing, Autumn Lane, and as 007 all had door-to-door eater than one-eighth of an the Maintenance Director of finding at the time of Electric	К 3		Fiber strips were installed on the sm barrier doors on Bluebird Wing, Autu Lane, and door set 007, making the gap between the doors less than 1/8 this project was completed on 11/23/ The Building Services Director or his designee will conduct random month audits of the smoke barrier doors in facility to assure compliance with the gap width regulation. Results of aud will be summarized at the quarterly Of Assessment and Assurance Commit Meeting. After 1 year, the Quality Assessment and Assurance Commit will re-evaluate the need and frequer for continued compliance monitoring The Director of Building Services is responsible for overall compliance we this regulation. Completion Date: 12/6/2021	umn air b inch; /21. s hly the e air liting Quality ttee ncy J.	12/6/21
	complies with NFP/	Electric as or related gas piping A 54, National Fuel Gas Code, d equipment complies with					

Facility ID: 00116

If continuation sheet Page 7 of 13

		AND HUMAN SERVICES		FO	ED: 12/09/202 RM APPROVE NO: 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DATE SURVEY COMPLETED
		245372	B. WING _		10/26/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ST LUKE	S LUTHERAN CARE	CENTER			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 511	NFPA 70, National	Electric Code. Existing ntinue in service provided no	K 51	1	
	by: Based on observat facility failed to mail physical accessibilit resident accessible NFPA 101 (2012 ec sections 19.5.1.1 a edition), National E and NFPA 99, (201 Facilities Code, sec condition could hav residents within the Findings include: On 10/26/2021, being it was revealed by of corridor of Sunrise found unsecured.	NT is not met as evidenced tion and staff interview, the ntain proper security and ty to an electrical panel in a e corridor in accordance with dition), Life Safety Code, nd 9.1.2, NFPA 70 (2011 lectrical Code, section 110.26, 2 edition), Health Care ction 6.3.2.2.1.3. This deficient re a patterned impact on the e facility. tween 10:00 AM to 12:30 PM, observation that in the resident Wing, an electrical panel was ne Maintenance Director nt finding at the time of		On 10/27/21, doors to the electrical par 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 to 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	of
	discovery. Electrical Systems CFR(s): NFPA 101	- Maintenance and Testing	K 91	4	12/6/21
	Hospital-grade rece	- Maintenance and Testing eptacles at patient bed e deep sedation or general			

Facility ID: 00116

If continuation sheet Page 8 of 13

		AND HUMAN SERVICES	1			FORM	12/09/2021 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION 01 - Main Building 01		E SURVEY PLETED
		245372	B. WING			10/2	26/2021
NAME OF	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUK	ES LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 914	anesthesia is administallation, replace testing is performed documented perfor listed as hospital-gu- tested at intervals r isolation monitors (intervals of less tha actuating the LIM te which activates bot LIM circuits with au manual test is perfor equal to 12 months 6.3.3.2 after any r electric distribution maintained of requir repairs or modificat area tested, and re 6.3.4 (NFPA 99) This REQUIREMED by: Based on a review and staff interview, receptacle testing of (2012 edition), Hea section(s) 6.3.3.2, 6 deficient condition of impact on the resid Findings include: On 10/26/2021 betw was revealed during documentation that for review was inco outlet testing forms do not meet the reor make it undetermin	nistered, are tested after initial ment or servicing. Additional d at intervals defined by mance data. Receptacles not rade at these locations are not exceeding 12 months. Line LIM), if installed, are tested at an or equal to 1 month by est switch per 6.3.2.6.3.6, h visual and audible alarm. For tomated self-testing, this ormed at intervals less than or a. LIM circuits are tested per repair or renovation to the system. Records are ired tests and associated tions, containing date, room or	K	914	Updated forms for receptacle testin been received and will be used for documentation of receptacle testing receptacle testing forms will be date upon completion of receptacle testing The Building Services Director will r all receptable testing forms for completion. The Director of Building Services is responsible for overall compliance of this regulation. Completion Date: 12/6/2021	g. All ed ng. review	

Facility ID: 00116

If continuation sheet Page 9 of 13

		AND HUMAN SERVICES			FORM	: 12/09/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245372	B. WING _		10/	26/2021
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 914	Continued From pa	ge 9	K 91	14		
	verified this deficier discovery.	e Maintenance Director nt finding at the time of - Essential Electric Syste	K 91	18		12/6/21
	Maintenance and T The generator or of and associated equ service within 10 se criterion is not met process shall be pr capability for the life Maintenance and te transfer switches at with NFPA 110. Generator sets are under load 30 minu day intervals, and e months for 4 contin under load conditio simulated cold start transfer of all EES competent personn stored energy powe accordance with NF circuit breakers are program for periodi components is esta manufacturer requi maintenance and te readily available. El circuits are marked separate from norm the possibility of da	ther alternate power source aipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this a safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test ns include a complete t and automatic or manual loads, and are conducted by tel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a				

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		AND HUMAN SERVICES	I		FORM	12/09/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	· · ·	E SURVEY IPLETED
		245372	B. WING		10/	26/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ST LUKE	ES LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	installations. 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMEN by: Based on a review and staff interview, Emergency Power (2012 edition), Hea section(s) 6.4.1.1, 6 (2010 edition), Sta Standby Power Sys deficient condition of impact on the resid Findings include: On 10/26/2021 betw was revealed during no evidence was av facility emergency g tested at least once exercise the transfe of a long term power An interview with th verified this deficient discovery. Gas Equipment - C Greater than or equ Storage locations av ventilated in accord 5.1.3.3.3. >300 but <3,000 cu	NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced of available documentation the facility failed to test the Supply System per NFPA 99 Ith Care Facilities Code, 5.4.4.1.3, 6.5.4, and NFPA 110 andard for Emergency and stems, section 8.4.9. This could have a widespread ents within the facility. ween 12:30 PM to 03:00 PM, it g documentation review that vailable to confirm that the generator was being load-bank e within every 36 months to er switch under the conditions er outage. Ne Maintenance Director th finding at the time of ylinder and Container Storage ual to 3,000 cubic feet re designed, constructed, and lance with 5.1.3.3.2 and	KS	On 11/30/21, Interstate Pow completing load-bank testing facility's generator. The Building Services Direct responsible for scheduling th of load-bank testing at least every 36 months. The Building Services Direct responsible for overall comp this regulation. Completion Date: 12/6/2021	g on the or will be ne completion once within or is liance with	12/6/21

Facility ID: 00116

If continuation sheet Page 11 of 13

		AND HUMAN SERVICES				FORM	12/09/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245372	B. WING	i		10/2	26/2021
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER			219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 923	within an enclosed limited- combustible gates outdoors) that gases are not store separated from com- sprinklered) or encl noncombustible con 1/2 hr. fire protection Less than or equal In a single smoke of cylinders available of care areas with an or equal to 300 cub stored in an enclose handled with precare A precautionary sig each door or gate of where the sign inclu- minimum "CAUTIO STORED WITHIN Storage is planned of which they are re- Empty cylinders are cylinders. When fai integral pressure ga considered empty is are marked to avoid in the open are pro- 11.3.1, 11.3.2, 11.3.7. This REQUIREMEN by: Based on observate facility failed to mai storage and manage edition), Health Car 11.3.2.3, 11.3.4, 11.	interior space of non- or e construction, with door (or it can be secured. Oxidizing d with flammables, and are nbustibles by 20 feet (5 feet if osed in a cabinet of nstruction having a minimum on rating. to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than ic feet are not required to be ure. Cylinders must be utions as specified in 11.6.2. n readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES) NO SMOKING." so cylinders are used in order eceived from the supplier. e segregated from full cility employs cylinders with auge, a threshold pressure s established. Empty cylinders d confusion. Cylinders stored tected from weather. .3, 11.3.4, 11.6.5 (NFPA 99) NT is not met as evidenced tion and staff interview, the ntain proper medical gas pement per NFPA 99 (2012 re Facilities Code, sections .6.2.3, 11.6.5 This deficient e a widespread impact on the	K	923	The doors to the metal cabinet use storage in the Medical Gas Storage (A314C) will be kept shut at all time staff members are not accessing su from the cabinet. Oxygen cylinders with regulators ap will be stored in the empty storage r in the Medical Gas Storage Room.	Room s that upplies pplied racks	

Facility ID: 00116

		AND HUMAN SERVICES			FORM	12/09/202 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245372	B. WING		- 10/2	26/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	•	
ST LUK	ES LUTHERAN CARE	CENTER		1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
K 923	Findings include: 1. On 10/26/2021 to PM, it was revealed Gas Storage Room storage within 5 fee 2. On 10/26/2021 to PM, it was revealed Gas Storage Room of oxygen cylinders racks. An interview with th	age 12 between 10:00 AM to 12:30 d by observation that the Med h (A314C) had combustible et of the oxygen cylinders. between 10:00 AM to 12:30 d by observation that the Med h (C12A) had mixed storage in the empty/full storage the Maintenance Director cient findings at the time of	К 9	23 has been posted inst place regulators on a the tank is needed. The Building Service designee will conduc audits of the facility's Storage Rooms to as storage cabinet door oxygen cylinders with are stored in the emp Results of auditing w the quarterly Quality Assurance Committe year, the Quality Ass	tructing staff not to an oxygen tank until es Director or his et random monthly s Medical Gas ssure that metal rs are shut and n regulators applied pty storage rack. vill be summarized at Assessment and ee Meeting. After 1 essment and ee will re-evaluate the for continued ng. ling Services is all compliance with	

Facility ID: 00116

If continuation sheet Page 13 of 13



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 <u>only a suggestion</u> 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

St Lukes Lutheran Care Center November 19, 2021 Page 2

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.

M. Pig

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00116	B. WING		C 10/28/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST LUKE	S LUTHERAN CARE	CENTER	TH RAMSEN RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure and orders are issued. F electronic plan of co	S: 3/21, a licensing survey was acility by surveyors from the eent of Health (MDH). Your OT in compliance with the MN of the following correction Please indicate in your prrection you have reviewed				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 11/26/21

Electronically Signed

STATE FORM

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED C
		00116	B. WING	· · · · · · · · · · · · · · · · · · ·	10/28/2021	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ST LUKE	ES LUTHERAN CARE	CENTER	UTH RAMSEY ARTH, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	these orders and id be completed.	lentify the date when they will				
	SUBSTANTIATED, were cited due to a facility prior to surve H5372033C (MN7 H5372036C (MN5 H5372037C (MN3 H5372038C (MN6 H5372040C (MN7 The following comp UNSUBSTANTIATE	7129) 6083) 1812) 7603)				
	(MN68195). Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far lo Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix nute/rule out of compliance is hary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and				
	receipt of State lice the Minnesota Dep Informational Bullet https://www.health.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00116	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST LUKE	ES LUTHERAN CARE	CENTER	UTH RAMSEY ARTH, MN 560	13		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
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	Department of Hea you electronically. is necessary for St enter the word "con text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm PLEASE DISREGA	ted on the attached Minnesota alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic breess, under the heading ne date your orders will be electronically submitting to the nent of Health. ARD THE HEADING OF THE N WHICH STATES,				
	"PROVIDER'S PLA APPLIES TO FEDI THIS WILL APPEA IS NO REQUIREM CORRECTION FC	AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE. THERE IENT TO SUBMIT A PLAN OF OR VIOLATIONS OF TE STATUTES/RULES.				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			12/6/21
	that is directed tow through positioning implemented and r comprehensive res of nursing services	f motion. A supportive program vard prevention of deformities g and range of motion must be maintained. Based on the sident assessment, the director must coordinate the nursing care plan which				
	receives appropria	th a limited range of motion te treatment and services to motion and to prevent further of motion.				
	This MN Requirem	ent is not met as evidenced				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00116		LE CONSTRUCTION		LETED
						0/2021
AME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TLUKE	ES LUTHERAN CARE	CENTER	JTH RAMSE RTH, MN 50			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLE
2 895	Continued From pa	age 3	2 895			
	by: Based on observat review the facility fa motion program for completed for 1 of with limited range of Findings include: R12's face sheet, p admission date of diagnoses of parap your trunk, and leg filled blisters betwee backbone), obesity damage). R12's admission M assessment dated intact cognition, limi lower extremities a 2 or more persons bathing. R12's Range of Mo Assessment dated indicated R12 had ADL's, is non-amb and active range of complete upper rar assistance with low paraplegic, has ser body, is unable to a significant range of joints are stiff. R12's care plan da an alteration in actii independent with u	ion, interview and document ailed to ensure a range of r lower extremities was 2 residents (R12) reviewed		St. Luke s Lutheran Care Co committed to providing a rang program to improve or mainta- residents joint mobility and strength. Even though the nu assistant Resident Assignme stated that R12 was to receiv motion exercises daily with a nursing assistant staff did no- provide the exercises as dire A copy of the range of motion developed by the Therapy De- was in the comprehensive ca- binder. A copy has been place In-Room Care Plan folder in the resident s bathroom; an app ROM exercises is also written comprehensive care plan. To assure that R12 and other receive range of motion exerc directed, the station charge nd designee will be responsible with the resident and nursing see if the nursing assistant per range of motion exercises as The RN Resident Care Coord charge nurse will be responsible externing a nursing order in the electronic health record for the charge nurse to verify completed exercises scheduled during the document this verification in the resident s electronic medication treatment record. The charge verification and documentation been added to the facility s the Motion Procedure. On 10/27/21, the Director of posted a memo at each nursing	ge of motion ain muscle rsing nt sheet re range of m cares, the t consistently cted. n exercises epartment ire plan ed in R12 s the proach for n in R12 s residents cises as urse or for checking assistant to erformed directed. dinator or ible for e resident s ne station etion of heir shift and the on step has Range of Nursing	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00116	B. WING		10/28/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ST LUKE	ES LUTHERAN CARE	CENTER	JTH RAMSE RTH, MN 5		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
2 895	Continued From pa	ige 4	2 895		
	 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. 			with instructions that nursing staff during shift report through 11/7/21 sign and date after reading. The r	, and
				discussed the importance of comp range of motion exercises at the frequency specified in the care pla well as importance of NA docume of completion in Matrix Care Assis	an, as ntation
sheet indicat completed fin	Point of Care range sheet indicated ran completed five time	e of motion documentation ge of motion once a day was es in August, eight times in ven times in October, 2021.		with the nursing assistant and res verify completion of exercises and document completion in EMAR. The facility s Range of Motion Ex Procedure is included in the Licer	o check ident to I kercise
	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			Nurse Orientation Checklist and N Assistant Orientation Checklist for Nursing Department employees. On a weekly basis for one month monthly, the Director of Nursing of designee will randomly audit documentation of verification of R cares by nursing assistant staff in	lursing r all new and then r her OM Matrix
 and staff have not completed range of mothis 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 undischarge a range of motion program was prescribed for his legs. PT indicated nursing 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 listed print out capable of doing the listed	his legs since thera During interview on physical therapist (I	py ended. 10/27/21, at 9:08 a.m., PT) indicated R12 received		Care Assist and documentation of verification of ROM cares in resid EMAR. On a monthly basis, the S Development RN or her designee randomly audit completion of rang motion exercises during nursing a	ents taff will je of
	of motion program was egs. PT indicated nursing was exercises to complete with sted how often to complete.		care audits. Results of auditing wi future compliance monitoring and In addition, the results will be sum at the quarterly Quality Assessme Assurance Committee Meeting. A	ll guide training. marized nt and	
	extremity range of r	motion without assistance.		year, the Quality Assessment and Assurance Committee will re-eval	uate the
	registered nurse (R motion to lower leged daily task sheets fo	10/27/21, at 9:26 a.m., N)-A indicated the range of s program was listed on the r the nursing assistants to not completed daily.		need and frequency for continued compliance monitoring. The Director of Nursing is respon- overall compliance with this regula Completion Date: 12/6/21	sible for

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00116	B. WING		10/28/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T LUKE	S LUTHERAN CARE	CENTER	UTH RAMSEY ARTH, MN 560			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
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2 895	Continued From pa	age 5	2 895			
	nursing assistant (I	n 10/27/21, at 9:34 a.m., NA)-A indicated she was ived range of motion exercises				
	indicated she was motion exercises in nursing assistant c	n 10/27/21, at 9:36 a.m., NA-B unsure if R12 required range o nitially but after looking at the are sheet, NA-B stated it is every a.m. while in bed.	f			
		n 10/27/21, at 9:44 a.m., R12 ot had any range of motion /25/21.				
	RN-B indicated ger instructions from the bathroom, but R12 RN-B did locate the communication bin included instruction exercises to be con	der at the nurses station that ns for range of motion mpleted for 5 exercises with hand written note stating				
	director of nursing wasn't completed of The DON was able the communication	n 10/28/21, at 8:42 a.m., the confirmed the range of motion daily and it should have been. to locate the instructions in h book but indicated it should in the bathroom but was not.				
	Motion" undated, ir - The purpose is to through as full a ra improve or maintai strength, prevent c	procedure titled "Range of included: move the resident's joints nge of motion as possible, to n joint mobility and muscle ontractures, increase strength ce, reduce pain and prevent				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00116	B. WING			C 10/28/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
T LUKE	S LUTHERAN CARE	CENTER	JTH RAMSEY RTH, MN 560				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 895	Continued From pa	ige 6	2 895				
	guidelines included	mobility. are plan documentation identify the appropriate ch to list range of motion as an					
	Motion" dated 10/14 - A range of motion on each resident up annually and signifi - The therapy depa screen residents if to joint mobility. - The resident or hi contacted if therapy evaluation. If appro- will be contacted ar evaluation will be m - Therapy recommender exercises and/or m	assessment will be completed oon admission, quarterly, cant change. rtment will be contacted to indicated for concerns related s/her responsible party will be y staff recommends an oved, the resident's physician nd a request for a therapy					
	The director of nurs review/revise polici implementation of r proper assessment implemented. The on the policies and evaluating and mor implementation of t developed, with the	hese policies could be results of these audits being ty's Quality Assurance					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					

Minneso	ta Department of He	alth		F	ORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	· · · ·	DATE SURVEY COMPLETED
		00116	B. WING		C 10/28/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
OTLUKE		1219 SOU	TH RAMSE	Y	
SILUKE	S LUTHERAN CARE	CENTER BLUE EAI	RTH, MN 56	013	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE
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				DEFICIENCY)	
21134	Continued From pa	ge 7	21134		
21124	-	-	21134		12/6/21
21134	Sanitation, storage	70 Supb. 2. Dishwashing;	21134		12/0/21
	Camation, Clorage				
		e. All utensils and equipment			
		cleaned, and food-contact			
		s and equipment must be			
		eatment and must be stored s to be protected from			
		aned and sanitized equipment			
		be handled in a way that			
	protects them from	•			
	•	ent is not met as evidenced			
	by:			Ot Lude's Lutherer Ores Orester Free	
		on, interview, and document ailed to ensure dishwashing		St. Luke's Lutheran Care Center Food	
		1 dishmachine was		Storage Policy states that leftover food stored in covered containers or wrapp	
		ored. In addition, the facility		carefully and securely. Each item is cl	
		opened containers of food in 1		labeled and dated before being	
		ator, and to ensure pans were		refrigerated. Leftover food is used with	nin 5
	completely dry befo	re storing. Furthermore, the		days or discarded. All food items will b	
		ure dietary staff received		checked to assure that foods will be	
		an on-going basis for 3 of 3		consumed by their "safe used by date	s" or
		ces director (SD)-D, assistant		discarded.	
		services (ADCS)-E, and cook potential to affect all 64		On 10/27/21, the Director of Culinary	ere
		served food from the kitchen.		Services assured that all open contair of refrigerated food were covered, lab	
				and dated following facility policy. On	
	Findings include:			ongoing basis, the Director of Culinary	
	-			Services or designee will conduct rand	
		ion and interview on 10/25/21,		weekly audits of open containers of	
		D-D and during the initial tour		refrigerated foods to assure compliant	ce
		erved a large metal bowl in a		with facility food storage policy.	
		The bowl was covered with		On 10/27/21, the Ecolab representativ	
		uminum foil. Handwritten on bran) cookies" and date of		trained Director of Culinary Services a dietary staff in the use of the	nu
		dark colored, raw dough.		3-compartment sink. On an ongoing b	asis
		lough was for bran cookies		the Director of Culinary Services or	
Minnoacta D	epartment of Health	5			

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ta Department of He	ealth			
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	00116	B. WING		C 10/28/2021
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	1219 501			
S LUTHERAN CARE	BLUE EA	RTH, MN 56	6013	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE COMPLETE
Continued From pa	age 8	21134		
and was good for a multiple jelly roll pla CSD-D was asked surfaces were note staff to run them th Observed multiple vertically, touching acknowledged inar cutting boards coul bacteria to grow. O dish washing sink. a near by cupboard of October. During an observat the bowl of bran co was still in the refri- three-compartment Sink and Surface O poster was posted and Surface Clean expiration date of 8 ledge above the sin website, measurent solution could be ta 65 degrees Fahrent five second dip into seconds for the col compare the strip a vial. The required p (dodecylbenzenest acid was outlined b chart. During an interview at 11:08 a.m. ADCS training for his role working on his CDI ADCS-E stated he	a couple of weeks. Observed ans stacked upside down. to look at the first few, and the ed to be wet. CSD-D directed rough the dishmachine again. cutting boards stacked one another. CSD-D opropriate storage of pans and d create an environment for observed a three-compartment The monitoring log hanging on d door was blank for the month tion on 10/26/21, at 11:00 a.m., okie dough in large metal bowl gerator. At the t sink, an Ecolab Smart Power Cleaner Sanitizer instructional above the sink. Ecolab Sink er Sanitizer Test strips with 8/2022, were noted on the nk. According to Ecolab nents of the chemical sanitizing aken at any temperature above wheit. Measurement required a o the test solution, allowing 10 for change to occur, and against the color chart on the opm (parts per million) DDBSA ulfonic acid) and ppm lactic oy a black box on the color		designee will conduct random wee audits of completed sanitizer logs staff setting up and testing sanitati levels in the 3-compartment sink. On 10/27/21, the Director of Culina Services assured that staff presen- re-educated on assuring all pans a completely dried prior to stacking. commercial cutting board rack was ordered for drying and storage of boards. On an ongoing basis, the of Culinary Services or designee w conduct random weekly audits of p pan and cutting board drying and s On 11/30/21, the Director of Culin Services will hold a mandatory For Service Training Meeting for all die staff that will cover the following to 1. Food storage and labeling 2. 3-Compartment Sink training i procedure for monitoring the sanit solution 3. Drying and Storage of cutting and pans On an ongoing basis, all dietary st receive training upon hire on the a topics. Results of the Dietary Department will be summarized by the Director Culinary Services at the quarterly Assessment and Assurance Comm Meeting. After 1 year, the Quality Assessment and Assurance Comm Will re-evaluate the need and frequ continued compliance monitoring. The Director of Culinary Services responsible for overall compliance this regulation. Completion Date: 11/18/21	and ion ary ary it were are A s cutting Director vill proper storage. ary od etary od etary opics: including izing boards aff will bove auditing r of Quality mittee uency for is
	PROVIDER OR SUPPLIER SLUTHERAN CARE SUMMARY STA (EACH DEFICIENCI REGULATORY OR L Continued From para and was good for a multiple jelly roll pla CSD-D was asked surfaces were note staff to run them th Observed multiple vertically, touching acknowledged inap cutting boards coul bacteria to grow. O dish washing sink. a near by cupboard of October. During an observat the bowl of bran co was still in the refright three-compartment Sink and Surface Clean expiration date of 8 ledge above the sin website, measurent solution could be ta 65 degrees Fahrent five second dip into seconds for the col compare the strip a vial. The required p (dodecylbenzeness acid was outlined b chart. During an interview at 11:08 a.m. ADCS training for his role working on his CDI ADCS-E stated he	OF CORRECTION IDENTIFICATION NUMBER: 00116 00116 PROVIDER OR SUPPLIER STREET AD 21219 SOU BLUE EA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION) 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 11:0	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING O0116 B. WING	IT OF DEFICIENCIES OF CORRECTION (M) PROVIDERSUPPLIERCIAN DENTIFICATION NUMBER: (PC) MULTIPLE CONSTRUCTION A BUILDING: B WING O0116 B WING PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION NUMBER: REGULATORY OR LG DENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTIVE REGULATORY OR LG DENTIFYING INFORMATION) Continued From page 8 21134 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 dataff to run them through the dishmachine again. Observed multiple cutting board stacked vertically, touching one another. CSD-D a cknowledged inappropriate storage of pans and cutting board cory as blank for the month of October. 21134 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 Test strips with expiration date of 8/2022, were noted on the ledge above the sink, Ecolab Smart Power 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 codure for monitoring the sanit exold was outlined by a black box on the color chart. 3. Drying and Storage of cutting and pans 3. Drying and Storage of cutting and pans 3. Drying and Assurance Corm will re-evaluate the need and frequired a training for his role, adding

If continuation sheet 9 of 19

	ta Department of He IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,			PLETED
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		00116	B. WING			28/2021
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST		•	
		1219 50				
ST LUKE	S LUTHERAN CARE	CENTER	ARTH, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21134	Continued From pa	age 9	21134			
	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.					
	at 11:30 a.m., with walk-up refrigerato the bowl of bran do and served bran co Sunday nights. C-A for two to three we was nothing that in recipe to see if it in lasted in the refrige recipe on a card ar the raw dough. C-A make smaller batch with ADCS-E in wa container of Mrs. C approximately one- not have a date op stated, "It's not data adding if dated, it w container of Monar observed with appr container; the cont opened mark on it. been dated, then d	v and observation on 10/26/21, ADCS-E and C-A at the r, C-A was asked to remove ough. C-A stated they made pokies on Wednesday and A stated the dough was good eks, but but admitted there dicated that. C-A obtained the dicated how long the dough erator. It was a hand-written nd did not include shelf-life for A stated they should probably hes of dough. At 11:34 a.m., ilk-in refrigerator, observed a Gerry's potato salad with -fourth left. The container did ened mark on it. ADCS-E ed; its supposed to be dated," vould be good for five days. A rch brand salad dressing was roximately one-eight left in the ainer did not have a date ADCS-E stated it should have iscarded after being opened ge bunch of green onions				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00116	B. WING		10/28/	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ST LUKE	ES LUTHERAN CARE	CENTER	JTH RAMSEY RTH, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21134	Continued From pa	ge 10	21134			
	date of 9/22. ADCS still okay to serve re- inspect them. ADC2 policy or reference knowing how long p were good for, addi for seven days no for vendor package During an interview CSD-D could not re- provided to staff on including monitoring CSD-D admitted sh process, but did no training. In addition responsibility to ove followed regulations effectiveness of the stated she reminde to test it. CSD-D wa tested the solution they stated did not	were observed with received a-E did not know if they were esidents; he would need to S-E stated there wasn't a tool that he was aware of for produce and opened foods ing "we say left-overs are good p matter what it is, and 5 days ad food like potato salad." Toon 10/27/21, at 9:15 a.m., ecall when training was the three-compartment sink, g the sanitizing solution. The was to be the expert for this t recall the last time she had , CSD-D admitted it was her ersee staff to ensure they is and monitored the the sanitizing solution. CSD-D d staff on Monday (10/25/21), as informed that staff had not the past two days because know how. CSD-D stated the ive was scheduled to come ng.				
	unopened foods we best by or expiration were good for five of to date food when of not monitor this. CS salad and salad dre dated, and of green	terview, CSD-D stated ere good until the manufacturer n date, and opened foods days. CSD-D stated staff were opened, but admitted she did SD-D was informed of potato essing being opened, but not n onions from September.	-			
	and onions should CSD-D stated she l cookie dough was g	ootato salad, salad dressing be discarded. In addition, looked up how long the bran good for and learned it was SD-D admitted the dough in				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00116		CONSTRUCTION	СОМ	E SURVEY PLETED C 28/2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		1 10/	20/2021
		1219 SO	UTH RAMSEY			
ST LUKE	ES LUTHERAN CARE	CENTER	ARTH, MN 560	13		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21134	Continued From pa	age 11	21134			
	discarded and sma forward. Furthermo provide records that dating foods when good for after open stacking, and not s During an interview the Ecolab represe CSD-D and staff ho solution in the three provided a list of si received the trainin During an interview administrator statin findings with the th the wet pans, bran after opening. The findings from the lat	on 10/28/21, 13:27 p.m. the g she was aware of the ree-compartment sink, but not dough, and foods not labeled administrator stated after ist survey, she didn't expect pected staff to be monitoring				
	During an observat at 10:00 a.m., C-C 10/27, with the Eco measuring the sam three compartment solution, but the mo date. C-C stated sh the solution. At that and wrote the infor the cupboard door. Facility policy titled Dishwashing, dated cookware would be assure all dishes w	tion and interview on 10/28/21, stated she had training on olab representative on itizing solution. Observed the t sinks filled with water and ponitoring log was empty for this he had been too busy to test t point, C-C tested the solution mation on the log hanging on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00116	B. WING			C 0/28/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
T LUKE	ES LUTHERAN CARE	CENTER	JTH RAMSEY RTH, MN 560	13			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21134	Continued From pa	ige 12	21134				
	 34 Continued From page 12 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 foods should be checked to assure that foods (including leftovers) are consumed by their safe use dates or discarded. 						
	and implement poli staff have been edu regulations and mo sanitation requirem conducted to ensur brought to the quali dietary director or d implement policy an have been educate to ensure dishes ar before stacking/sto conducted to ensur brought to the quali	r or designee could develop cy and procedure to ensure all ucated and are following initoring dishmachine ents. Audits could be re compliance and results ity committee for review. The lesignee could develop and nd procedure to ensure all staff d and are following regulation nd pans are thoroughly dried ring. Audits could be re compliance and results ity committee for review. R CORRECTION: Twenty-one	F				

Minnesc	ota Department of He	alth		FO	RM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00116	B. WING		C 1 0/28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
		1219 SOU	TH RAMSE		
STLUKE	ES LUTHERAN CARE	CENTER BLUE EAI	RTH, MN 50	6013	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
21375	Continued From pa	ige 13	21375		
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375		12/6/21
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on observati review, the facility facontrol measures we urinary catheter car reviewed for cathet facility failed to ensi- performed during re- passes for 3 of 3 re- observed for infecti Findings include: R43's diagnosis rep- included diagnoses history of urosepsis complication of an in- infection), and urina R43's significant ch- (MDS) assessment was cognitively inta- vision, clear speech- understood and cou- MDS further indicat	infection caused a urinary tract		St. Luke's Lutheran Care Center has a well-established infection prevention an control program that includes procedure for hand hygiene and urinary catheter b care. The facility's Urinary Catheter Use, and Care Guide is written with the goal that residents with an indwelling catheter sh be free from complications of infection. Positioning of the closed urinary drainag system is an essential element of infect prevention. On 10/28/21, a 3M Command Hook wa mounted on a bookcase next to R43's recliner for catheter bag placement whe the resident is sitting in a recliner. A bur 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 a ongoing basis, the RN Resident Care Coordinator and station nursing staff wi	es ag all ge ion s s n igy w a br n
	of one staff for mov wheelchair.	ing about the facility in a		develop a plan for safe options for catheter bag placement for each reside with a catheter. On 10/29/21, the Director of Nursing	
/innesota D	epartment of Health	. ,	1	, .	

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED
			A. BUILDING	:	
		00116	B. WING		C 10/28/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ST LUKE	ES LUTHERAN CARE	CENTER	ITH RAMSE RTH, MN 50		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E COMPLET
21375	Continued From pa	ige 14	21375		
	indwelling catheter recurrent urinary tra	due to urine retention with act infections.		posted a memo at each nursing station with instructions that nursing staff rea	
	,			during shift report through 11/7/21, ar	
		blem dated 12/14/17,		sign and date after reading. The men	
		urinary retention. In addition, a		included re-education on catheter ba	
		dated 12/16/20, indicated there		care including the facility expectation	
	•	or overall decline and ed to history of hospitalization		a catheter bag should never touch the floor or be attached to a waste baske	
	for urinary tract infe			The memo also included re-educatio	
		section with sepsis.		hand hygiene including the facility	
	During an observat	ion on 10/25/21, at 4:58 p.m.,		expectation that hand hygiene should	k
		nary drainage bag laying		occur before, during and after each	
	directly on the floor	to the right of her recliner.		resident's care was complete.	
				On an ongoing basis, hand hygiene a	
		ion on 10/25/21, at 5:04 p.m.,		urinary catheter bag care are include	
		being transported to the dining ir. The bottom of R43's urinary		the orientation checklist for new licen	Isea
		was hooked to the underside		nurses and nursing assistants. On a weekly basis for one month and	then
		and was dragged along the		monthly, the Infection Prevention and	
	floor to the dining re	<u> </u>		Control RN or her designee will rando	
				audit catheter bag care and hand hyp	giene.
		ion on 10/26/21, at 3:25 p.m.,		Results of auditing will guide future	
		age bag was observed hooked astebasket which was to the		compliance monitoring and training. I addition, the results will be summariz	
		, with the bottom of the bag		the quarterly Quality Assessment and	
	touching the floor.	, with the bottom of the bag		Assurance Committee Meeting. After	
				year, the Quality Assessment and	
				Assurance Committee will re-evaluat	e the
	Hand Hygiene			need and frequency for continued	
	During on charges	ion and interview on 10/05/01		compliance monitoring.	o for
		ion and interview on 10/25/21, ved trained medication aide		The Director of Nursing is responsible overall compliance with this regulation	
	•	's room and set her meal tray		Completion Date: 12/6/2021	11.
		e. TMA-B woke R41, helped			
		ned the curtains, assisted her			
		recliner and set up her meal			
		the room without performing			
		nd sanitizer dispenser was			
		all near the door. At 4:48 p.m.,			
	I MA-B took a mea	I tray into R54's room and set			

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМІ СОМІ	E SURVEY PLETED
		00116	B. WING	· · · · · · · · · · · · · · · · · · ·	10/2	28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ST LUK	ES LUTHERAN CARE	CENTER	JTH RAMSEY RTH, MN 560	13		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	it on an overbed tal from bed, put her s the bottom of the sl assisted her into a then set up her tray without performing sanitizer dispenser the door. At 4:58 p. room without perfor gloves, emptied R4 urinal. TMA-B empt flushed the toilet ar hand hygiene was new gloves and hel lift to transfer R43 i transfer was compl opened the curtains gloves. At 5:02 p.m in R43's room, TMA documents, then fo behind R43's hand hand hygiene and e asked if she cleaner resident rooms whe R41 and R54, and stated she thought not observed, TMA should have. TMA- important to preven between residents. During an interview DON was asked if i hang a urinary drait or lay it directly on t	ble. TMA-B helped R54 up hoes on, placing her palm on hoes to get them in place, wheelchair, then to a recliner, 7. TMA-B exited the room hand hygiene. A hand was observed on the wall near m., TMA-B entered R43's rming hand hygiene, donned .3's urinary drainage bag into a tied the urinal into the toilet, nd removed her gloves. No berformed. TMA-B donned ped a nurse with a mechanical nto a wheelchair. Once the ete, with gloved hands, TMA-B s, and then removed her ., while standing near the door A-B made notations on paper lded them and tucked them sanitizer dispenser, performed exited the room. TMA-B was and her hands in between en delivering meal trays for providing care to R43, TMA-B she did. When informed it was -A stated she was sorry, and B confirmed hand hygiene was at the spread of germs				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00116	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	Сом	E SURVEY PLETED C 28/2021
					107.	20/2021
	PROVIDER OR SUPPLIER	1219 SO	DDRESS, CITY, ST UTH RAMSEY	IATE, ZIP CODE		
ST LUKE	ES LUTHERAN CARE	CENTER	ARTH, MN 560	13		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 16	21375			
	DON stated "that sl that's not okayit s hanging from the w informed of observa between resident c were expected to c and exiting a resider	erneath her wheelchair. The hould never happen happen, houldn't be on the floor or vastebasket." In addition, when ations of lack of hand hygiene ares, the DON stated staff lean their hands when entering ents room to prevent cross ing they educated staff on that	9			
	the administrator w to lack of hand hyg and handling of a u administrator stated perform hand hygie acknowledged disp	on 10/28/21, at 12:47 p.m., as informed of findings related iene between resident cares, rinary drainage bag. The d she expected staff to ene between residents and ensers were readily available om, so there was no excuse ene.				
	Hand Hygiene with indicated the policy guidelines. The pol hands with soap an and at a minimum l contact and after ha items. When hands alcohol-based hand hands in all other c	Policy and Procedure for revised date of 11/2017, was based on CDC icy directed staff to wash d water when visibly soiled, before and after each resident andling any contaminated were not visibly soiled, d rub for decontaminating linical situation. Examples d after any resident contact, g gloves.				
	Care Guide dated 1 with an indwelling c complications of inf washed before and	Urinary Catheter Use and 11/2004, indicated the resident atheter shall be free from fection. Hands would be after performing any ents with urinary catheters.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 10/28/2021	
		00116	B. WING			
NAME OF PROVIDER OR SUPPLIER STREET A			DDRESS, CITY, STATE, ZIP CODE		10/26/2021	
		1219 SOL	JTH RAMSE			
SILUKE	ES LUTHERAN CARE	CENTER BLUE EA	RTH, MN 56	013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
21375	Continued From pa	age 17	21375			
	director of nursing review and revise p needed, educate no care, and hand hyg residents. The DOP ongoing audits to e	THOD OF CORRECTION: The (DON), or designee, could policy and procedures as ursing staff on urinary catheter jiene between care of N or designee could conduct insure compliance. R CORRECTION: Twenty-one				
21915	(21) days. MN St. Statute 144.651 Subd. 27 Patients &		21915		12/6/21	
	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.					
	by: Based on documer facility failed to atte council on at least	ent is not met as evidenced at review and interview, the empt to organize a family an annual basis. This had the II 64 residents who reside in r families.		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 Counci A Family Council Interest Survey was	1.	

STATE FORM

LPM811

If continuation sheet 18 of 19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		00116			10/28/2021		
AME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
T LUKI	ES LUTHERAN CARE	CENTER	JTH RAMSE RTH, MN 50				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21915	Continued From page 18		21915				
	During interview or social worker indica an active family col became an issue, t communicate with indicated in the pas out and per the doo early 2019. The so social services ass family council During interview or social services ass attempt to form a fa indicated the facility communication lett meetings througho SUGGESTED MET administrator or he monitoring systems to initiate the family	a 10/26/21, at 3:30 p.m., the ated the facility used to have uncil, but once Covid-19 the newsletters were used to families. The social worker st a survey or letter was sent cumentation was last done in ocial worker indicated the istant was responsible for a 10/27/21, at 8:23 a.m. the istant confirmed the last amily council was 2019 and y had decided to use a iter versus family council ut the Covid-19 pandemic. THOD OF CORRECTION: The signee could ensure attempts op a family council. The ir designee could develop s to ensure attempts are made		enclosed giving each recip to respond regarding inter- or virtual attendance, or to option of involvement. Th asked to check if they wer facilitating Family Council Family Council meeting ha 12/6/21 for those who are On an ongoing basis, infor Family Council will be inclu- admission packets for res- member/responsible perso Family Council Meetings v on a quarterly basis. The Administrator is respon overall compliance with th Completion Date: 12/06/2	est in in-person declined the ey were also re interested in Meetings. A as been set for interested. rmation on uded in resident idents and family on. vill be scheduled onsible for is regulation.		