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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LS9Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**
2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/21/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria King, Unit Supervisor 03/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/12/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/29/13 CO. LS9Q

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5338

St John's Lutheran Home was not in substantial compliance with Federal participation requirements at the time of the February 7, 2013 standard survey. On March 21, 2013, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on March 12, 2013, The Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on February 7, 2013, effective March 15, 2013. Refer to the CMS-2567b for both health and life safety code.

Effective March 15, 2013, the facility is certified 170 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5338

April 12, 2013

Mr. Scot Spates, Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, Minnesota 56007

Dear Mr. Spates:

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

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

Effective March 15, 2013 the above facility is certified for:

170 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 170 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Scot Spates, Administrator
St. Johns Lutheran Home
901 Luther Place
Albert Lea, Minnesota 56007

March 26, 2013

RE: Project Number S5338023

Dear Mr. Spates:

On February 25, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 21, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 12, 2013, the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 7, 2013, effective March 15, 2013 and therefore remedies outlined in our letter to you dated February 25, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900
Telephone: (651)201-4117 Fax: (651)215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245338	A. Building B. Wing	3/21/2013

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/15/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/08/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/27/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/27/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/26/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MK/cbl	03/26/2013	08769	03/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/7/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245338	01 - MAIN BUILDING 01	3/13/2013

Name of Facility	Street Address, City, State, Zip Code
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	02/06/2013	ID Prefix Reg. # NFPA 101 LSC K0018	02/24/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/cbl	Date: 03/25/2013	Signature of Surveyor: 25822	Date: 03/13/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/4/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LS9Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**
2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **170** (L18)

13.Total Certified Beds **170** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	170			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 03/11/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/5/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

At the time of the February 2, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Documentation supporting the facility¿s request for a continuing waiver involving K67 was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9301

February 25, 2013

Mr. Scot Spates, Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, Minnesota 56007

RE: Project Number S5338023

Dear Mr. Spates:

On February 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Telephone: (507) 344-2716

Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 19, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 19, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 7, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 7, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

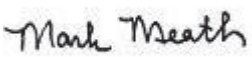
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5338s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 0 4 2013 Minnesota Dept of Health Mankato	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide cares as directed by R139's care plan in a manner that promoted improvement for healing, and/or prevention of further skin impairment, for 1 of 2 residents (R139) in the sample who were reviewed for pressure ulcers. Findings include: R139 who had a pressure ulcer, failed to receive repositioning care as directed by his written plan of care. R139 was admitted to the facility on 6/1/10 with	F 282 Approved 3/4/13	**F 282** A. Resident 139's care plan was reviewed by the RN Nurse Manager. All nursing staff working with resident 139 have been educated on the importance of following the care plan and specifically the importance of repositioning the resident per the care plan. B. The most recent Braden scale will be used to identify other residents at risk. Any resident with a score of 14 or less will be reassessed. Interventions will be established and added to the care plan as needed. Completion date: March 15, 2013.	3/15/13

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

Scot Spaeth | CEO/Administrator | 2/28/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	02/07/2013

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F 282	Continued From page 1 diagnoses that included: Parkinson's disease, muscle weakness, diabetes, stage 2 pressure ulcer, peripheral vascular disease and arteriosclerotic heart disease. R139's record was reviewed. A physician's note dated 1/17/13, indicated R139 had an open area on his coccyx due to moisture, that did not heal but was free of infection. The physician had prescribed Critic Aide (barrier cream) to moist area on coccyx twice daily as needed and leave open to air. R139's Care Plan dated January of 2013 indicated R139 was at risk for alteration in skin integrity related to (r/t) bruising, skin tears r/t reaching for grab bars/railings, poor coordination and balance, diabetes, current moisture associated skin disorder (MASD) on coccyx, and coumadin therapy. Staff interventions included: turn and reposition resident every two hours, implement pressure reduction procedures to include lowering the head of the bed to prevent friction, and to keep bedding wrinkle free. The care plan also identified R139 as requiring assistance of one staff with turning in bed and two staff to move up in bed, transfer and toilet with the assist of a mechanical lift. During observation of resident cares on 2/6/13 at 3:50 p.m., R139 was observed to be assisted out of bed with the use of a mechanical lift by nursing assistants (NA)-A and B and transferred into his wheelchair. At 5:00 p.m. R139 remained in his wheelchair and was wheeled from his room to the dining room for the evening meal. At 6:00 p.m. R139 was wheeled out of the dining room by NA-B to his room and placed beside his bed with	F 282	C. Education material related to care plans, repositioning, and skin interventions have been prepared by the RN Staff Education Director. Charge nurses will assure that all nursing staff have reviewed and understand education material at the start of their shift. Staff will sign education sheet. The Education Director will monitor. Completion date March 8th, 2013. Goal: Staff will understand the importance of following the care plan. Staff will be able to demonstrate knowledge of repositioning and other skin interventions. D. Charge nurses will audit repositioning every shift for one week then randomly for the next three weeks. Audits will be reviewed by the Director of Nursing and the Education Director. Findings from the audit will be presented to the Quality Assurance Committee.	

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F 282	Continued From page 2 his call light in his hand. At 6:42 p.m. NA's A and B entered R139's room and transferred him out of his wheelchair and into bed with the use of a mechanical lift. During interview with NA-A and NA-B, at the time of the observation, it was verified R139 had not been turned or repositioned since 3:50 p.m. (2 hours and fifty two minutes since last repositioning). When NA-A and NA-B transferred R139 into the bed and performed perineal care, R139 was observed to have a reddened area, approximately the size of a baseball, on his sacral area that was covered with barrier cream. The periphery of the area was bright red. R139's peri-rectal area was also noted to be quite red. The NAs verified R139 was frequently noted to have redness. A Wound Assessment form dated 1/30/13, identified R139 with a stage 2 ulcer on his coccyx. The ulcer was identified as free of drainage and odor, with epithelial tissue, and surrounding 8 cm (centimeter) by 7 cm area of redness. The wound bed was identified as dry, tender and peeling. The assessment also identified R139 as incontinent of urine. Interventions for skin maintenance included: air mattress, chair cushion, 2 hour repositioning, pillows and wedge for positioning, and Ensure nutritional supplements. During interview with registered nurse (RN)-A on 2/6/13 at 7:00 p.m., RN-A stated the area on R139's sacrum had been open for a long time. She stated she did not believe the area was actually a pressure area but was a MASD. However, RN-A stated that even though the etiology of the wound was unclear, R139 still required two hour repositioning.	F 282		

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F 282	Continued From page 3	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care that promoted improvement for healing, and/or prevention of, further skin impairment, for 1 of 2 residents (R139) in the sample who were reviewed for pressure ulcers. Findings include: R139 who had a pressure ulcer, failed to receive repositioning care as directed by his written plan of care. During observation of resident cares on 2/6/13 at 3:50 p.m., R139 was observed to be assisted out	F 314	**F 314** A. Resident 139's care plan was reviewed by the RN Nurse Manager. All nursing staff working with resident 139 have been educated on the importance of following the care plan and specifically the importance of repositioning the resident per the care plan. B. The most recent Braden scale will be used to identify other residents at risk. Any resident with a score of 14 or less will be reassessed. Interventions will be established and added to the care plan as needed. Completion date: March 15, 2013.	3/15/13

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F 314	Continued From page 4 of bed with the use of a mechanical lift by nursing assistants (NA)-A and B and transferred into his wheelchair. At 5:00 p.m. R139 remained in his wheelchair and was wheeled from his room to the dining room for the evening meal. At 6:00 p.m. R139 was wheeled out of the dining room by NA-B to his room and placed beside his bed with his call light in his hand. At 6:42 p.m. NA's A and B entered R139's room and transferred him out of his wheelchair and into bed with the use of a mechanical lift. During interview with NA-A and NA-B, at the time of the observation, it was verified R139 had not been turned or repositioned since 3:50 p.m. (2 hours and fifty two minutes since last repositioning). When NA-A and NA-B transferred R139 into the bed and performed perineal care, R139 was observed to have a reddened area, approximately the size of a baseball, on his sacral area that was covered with barrier cream. The periphery of the area was bright red. R139's peri-rectal area was also noted to be quite red. The NAs verified R139 was frequently noted to have redness. R139's record was reviewed. R139 had been admitted to the facility on 6/1/10 with diagnoses that included: Parkinson's disease, muscle weakness, diabetes, stage 2 pressure ulcer, peripheral vascular disease and arteriosclerotic heart disease. A physician's progress note dated 1/17/13, indicated R139 had an open area on his coccyx due to moisture, that did not heal, but was free of infection. The physician had prescribed Critic Aide (barrier cream) to moist area on coccyx twice daily as needed and leave open to air. R139's Care Plan dated January of 2013	F 314	C. Education material related to care plans, repositioning, and skin interventions have been prepared by the RN Staff Education Director. Charge nurses will assure that all nursing staff have reviewed and understand education material at the start of their shift. Staff will sign education sheet. The Education Director will monitor. Completion date March 8th, 2013. Goal: Staff will understand the importance of following the care plan. Staff will be able to demonstrate knowledge of repositioning and other skin interventions. D. Charge nurses will audit repositioning every shift for one week then randomly for the next three weeks. Audits will be reviewed by the Director of Nursing and the Education Director. Findings from the audit will be presented to the Quality Assurance Committee.	

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F 314	Continued From page 5 indicated R139 was at risk for alteration in skin integrity related to (r/t) bruising, skin tears r/t reaching for grab bars/railings, poor coordination and balance, diabetes, current moisture associated skin disorder (MASD) on coccyx, and coumadin therapy. Staff interventions included: turn and reposition resident every two hours, implement pressure reduction procedures to include lowering the head of the bed to prevent friction, and to keep bedding wrinkle free. The care plan also identified R139 as requiring assistance of one staff with turning in bed and two staff to move up in bed, transfer and toilet with the assist of a mechanical lift. A Wound Assessment form dated 1/30/13, identified R139 with a stage 2 ulcer on his coccyx. The ulcer was identified as free of drainage and odor, with epithelial tissue, and surrounding 8 cm (centimeter) by 7 cm area of redness. The wound bed was identified as dry, tender and peeling. The assessment also identified R139 as incontinent of urine. Interventions for skin maintenance included: air mattress, chair cushion, 2 hour repositioning, pillows and wedge for positioning, and Ensure nutritional supplements. During interview with registered nurse (RN)-A on 2/6/13 at 7:00 p.m., RN-A stated the area on R139's sacrum had been open for a long time. She stated she did not believe the area was actually a pressure area but was a MASD. However, RN-A stated that even though the etiology of the wound was unclear, R139 still required two hour repositioning.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure side rails utilized on resident beds met current safety standards for 3 of 6 residents (R140, R56, R149) in the sample reviewed for side rail use. The findings include: During observation of resident cares on 2/7/13 at 6:12 a.m., R140 was observed lying in her bed with bilateral 1/2 bed rails up on the top 1/2 of her bed. The bed rails were noted to have wide gaps between the vertical rails and there was large spacing between the mattress and the top rail. The rails were also noted to have wide spacing between the head of the bed and the top of the bed rail. The spacing between the vertical rails was measured to be 7 3/4" (inches). The spacing from the headboard to the first vertical rail was 6 3/4" and the spacing between the bed mattress and top rail measured 8" with the resident lying in bed. Review of R140's record revealed the resident was independent in bed mobility, but required staff assistance to transfer out of bed.	F 323	**F 323** A. Side rails that did not meet safety standards were removed from the beds of R140, R56, and R149 and will be replaced as needed with rails that are compliant with FDA guidelines dated March 10, 2006. Removal of the above mentioned side rails was completed on February 8, 2013. B. All remaining side rails have been measured and comply with the most recent FDA guidelines dated March 10, 2006. Completed February 8, 2013. C. All new beds purchased for St. John's will have side rails that follow the FDA guidelines.	2/8/13

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F 323	Continued From page 7 A Fall Risk assessment conducted for R140 11/10/12, indicated the resident was a high risk for falling. The assessment also indicated R140 had two 1/2 side rails on her bed which she used safely. A Side Rail assessment conducted for R140 last on 6/9/10, indicated the resident utilized the side rails for repositioning and indicated the side rails could be up at all times. The assessment lacked any assessment of the safety features of the side rails. During observation of resident cares on 2/7/13 at 6:15 a.m., R56 was observed lying in her bed with bilateral 1/2 bed rails up on the top 1/2 of her bed. The bed rails were noted to have wide gaps between the vertical rails and there was large spacing between the mattress and the top rail. The rails were also noted to have wide spacing between the head of the bed and the top of the bed rail. The spacing between the vertical rails was measured to be 7 3/4" (inches). The spacing from the headboard to the first vertical rail was 6 3/4" and the spacing between the bed mattress and top rail measured 8" with the resident lying in bed. Review of R56's record revealed the resident was independent in bed mobility, but required staff assistance to transfer out of bed. A Fall Risk assessment conducted for R56, dated 11/10/12, indicated the resident was at a mild risk for falling. The assessment also indicated R56 had two 1/2 side rails on her bed which she used safely.	F 323	D. The Director of Nursing and the Environmental Services Supervisor will assure that all new beds and side rails that are purchased meet FDA guidelines. Maintenance will tighten loose side rails and assure that they meet FDA guidelines. Process will be ongoing.	

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F 323	Continued From page 8 A Side Rail assessment conducted for R56 on 11/21/11, indicated the resident utilized the side rails with cueing for repositioning, and that the side rails could be up at all times. The assessment lacked any assessment of the safety features of the side rails. During observation of resident 149's room on 2/4/13 at 1:15 p.m., bilateral 1/2 side rails were observed to be in the up position on the top 1/2 of her bed. The bed rails were noted to have wide gaps between the vertical rails and there was large spacing between the mattress and the top rail. The rails were also noted to have wide spacing between the head of the bed and the top bed rail. R149's side rails were measured on 2/6/13 at 3:30 p.m. The spacing between the vertical rails was 7 3/4". the spacing from the headboard to the first vertical rail was 6 3/4", and the spacing between the bed mattress and top rail measured 8". Review of R149's record revealed the resident was dependent with bed mobility and required extensive staff assistance to transfer out of bed. A Fall Risk assessment conducted for R149 11/23/12, indicated the resident was a high risk for falling. The assessment also indicated R149 had two 1/2 side rails on her bed. A Side Rail assessment conducted for R149 last on 11/5/10, indicated the resident utilized the side rails for assistance with repositioning and indicated the side rails could be up at all times. The assessment lacked any assessment of the safety features of the side rails.	F 323		

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F 323	Continued From page 9 The most recent Food and Drug Administration (FDA) guidance for hospital bed dimensions dated 3/10/06, identified the following safety guidance for health care facilities related to side rail usage: Zone 1- any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. It is recommended that the space be less than 120 mm (4 ¾ inches), representing head breadth. Zone 6 - the space between the end of the rail and the side edge of the headboard or footboard. This space may present a risk of either neck entrapment or chest entrapment. Even though the FDA did not set guidance on dimensions the FDA guidance indicated this area was a potential threat for entrapment. Review of incident reports for the past year revealed no resident entrapment had occurred with the use of these side rails. During interview with the director of nursing (DON) on 2/7/13 at 8:30 a.m., the DON stated the facility had undergone an 'insurance audit' in the past year to look at side rails, and that their side rails had not been identified as a concern. The DON was unaware these side rails were outside the recommended standards for zone spacing as recommended by the FDA. She stated there was not a true system to assess the rails for spacing and confirmed the rails were in use because they were on the beds.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 10 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide parameters for the use of as needed (PRN) antipsychotic medications for 1 of 10 residents (R81) reviewed for unnecessary medications. Findings include: R81 had a physician's order for the PRN usage of Haldol, and Seroquel, (antipsychotic	F 329	**F329** A. The consulting Pharmacist and Nurse Manager reviewed resident 81's medication. Haldol and Seroquel had not been given for over 30 days. Doctor discontinued medication. B. The consulting Pharmacist has reviewed all resident taking antipsychotic medication. All parameters have been improved as needed. Completed on February 27, 2013. C. All new orders for antipsychotics will be reviewed by the consulting Pharmisist to assure that they meet appropriate parameters. D. The consulting Pharmacist will review medications monthly and medical records will monitor. The consulting Pharmacist will review monthly findings at the Quality Assurance meeting.	2/27/13

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F 329	Continued From page 11 medications), without adequately established parameters for use. R81 was admitted to the facility 4/16/12 with diagnoses including: dementia with behavioral disturbance and delusions. Review of the record identified R81 had orders for Haldol 2 mg (milligrams) po (orally) or IM (intramuscular injection) daily PRN for dementia with aggressive features, and Seroquel 25 mg po daily PRN for dementia with aggressive features. The Haldol order date was 7/12/12 and the Seroquel order date was 8/8/12. Both orders included: "....for dementia with aggressive features E/B (evidenced by) hitting staff, resisting assist with transfers and cares, disruptive yelling, verbal threats of physical violence to staff, disruptive sarcastic verbalizations to staff, residents and families, distract/divert with tasks, exercise, reminiscing, music, activities, assess for pain/discomfort, hunger, cold, toilet/reposition before giving, if used more than twice in seven days, notify MD (medical doctor)." Review of the behavior sheets from August 2012 to February 2013, indicated the resident had exhibited behaviors requiring the use of these PRN medications from 4 to 26 times per month. During interview with registered nurse (RN)-C on 2/6/13 at 2:30 p.m., she verified there had been no parameters established to indicate when to use the PRN Seroquel or the PRN Haldol. RN-C stated she guessed she would go by the severity of the behaviors and use the Seroquel for the less severe, and Haldol for the more severe. During interview with the consultant pharmacist	F 329		

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F 329	Continued From page 12 on 2/6/13 at 2:50 p.m., the pharmacist stated that there should have been parameters identified for the use of the Haldol and Seroquel to indicate which anti-psychotic medication should be utilized first.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure the consultant pharmacist monitored medication regimens to identify the potential use of unnecessary medications, including identifying parameters for the use of as needed (PRN) antipsychotic medications for 1 of 10 residents (R81) reviewed for unnecessary medications. Findings include: R81 had a physician's order for the PRN usage of Haldol, and Seroquel, (antipsychotic medications), without adequately established parameters for use.	F 428	**F 428** A. The consulting Pharmacist and Nurse Manager reviewed resident 81's medication. Haldol and Seroquel had not been given for over 30 days. Doctor discontinued medication. B. Consulting pharmacist has reviewed all resident taking antipsychotic medication. All parameters have been improved as needed. C. All new orders for antipsychotics will be reviewed by the consulting Pharmacist to assure that they meet appropriate parameters. D. Consulting pharmacist will review medication monthly and medical records will monitor. The consulting Pharmacist will review monthly findings at the Quality Assurance meeting.	2/27/13

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	245338	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	901 LUTHER PLACE ALBERT LEA, MN 56007

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F 428	Continued From page 13 R81 was admitted to the facility 4/16/12 with diagnoses including: dementia with behavioral disturbance and delusions. Review of the record identified R81 had orders for Haldol 2 mg (milligrams) po (orally) or IM (intramuscular injection) daily PRN for dementia with aggressive features, and Seroquel 25 mg po daily PRN for dementia with aggressive features. The Haldol order date was 7/12/12 and the Seroquel order date was 8/8/12. Both orders included: "....for dementia with aggressive features E/B (evidenced by) hitting staff, resisting assist with transfers and cares, disruptive yelling, verbal threats of physical violence to staff, disruptive sarcastic verbalizations to staff, residents and families, distract/divert with tasks, exercise, reminiscing, music, activities, assess for pain/discomfort, hunger, cold, toilet/reposition before giving, if used more than twice in seven days, notify MD (medical doctor)." Review of the behavior sheets from August 2012 to February 2013, indicated the resident had exhibited behaviors requiring the use of these PRN medications from 4 to 26 times per month. During interview with registered nurse (RN)-C on 2/6/13 at 2:30 p.m., she verified there had been no parameters established to indicate when to use the PRN Seroquel or the PRN Haldol. RN-C stated she guessed she would go by the severity of the behaviors and use the Seroquel for the less severe, and Haldol for the more severe. During interview with the consultant pharmacist on 2/6/13 at 2:50 p.m., the pharmacist stated that there should have been parameters identified for the use of the Haldol and Seroquel to indicate	F 428		

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	245338	A. BUILDING _____ B. WING _____	02/07/2013

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F 428	Continued From page 14 which anti-psychotic medication should be utilized first. He verified he had not identified this irregularity during his monthly reviews.	F 428		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 8 wings (2nd NE, 2nd SE, 1st N and 1st S) which were noted to have heavily soiled exhaust vents in resident bathrooms. During observation of cares throughout the survey it was noted the bathroom air exchange vents on the 2nd northeast (NE), 2nd southeast (SE), 1st North and 1st South wings were observed to be heavily soiled with dust and cobwebs. The dust was observed to hang from the vent housing and peripheral ceiling areas. During the environmental tour on 2/7/13 at 9:45 a.m. with the maintenance director the findings were verified. The maintenance director verified the facility had a bi-annual cleaning program to clean the vents,"But, that obviously is not enough" She stated, and verified the dust hanging throughout the wings was a problem.	F 465	**F 465** A. All exhaust vents in resident bathrooms have been cleaned as of February 26, 2013. B. All exhaust vents in resident bathrooms, resident rooms, corridors, and public areas will be checked once a month by maintenance staff. C. All exhaust vents will be cleaned as needed and at least quarterly. D. The Environmental Services Supervisor will monitor.	2/26/13

F 53380021

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

PRINTED: 02/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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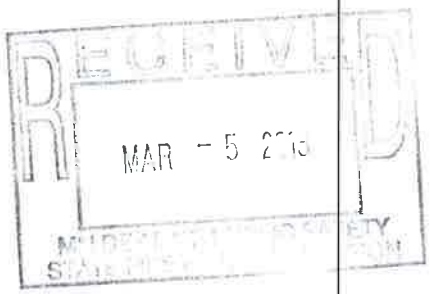
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey, St. Johns Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok w/ AW for K67 PS 3-11-13	

DC: 03.19.2013

EXIT: 02.07.2013



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

Scot Spates | CEO/Administrator | 2/28/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. Johns Lutheran Home building was constructed at 4 different times. The original building is a 3 story building and was constructed in 1960. It was determined to be of Type II(222) construction. In 1964, a 2 story addition was added to the northeast and southeast wings that was determined to be of Type II(222) construction. In 1967, a 2 story addition was constructed to the North and South that was determined to be of Type II(222) construction. In 1980, a 2 story addition was added to the South Annex and was determined to be Type II (111). Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as a Type II(111) building. The facility is fully sprinkled . The facility has a fire alarm system with full corridor smoke detection	K 000		

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K 000	Continued From page 2 and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 170 beds and had a census of 163 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K011 Fire rated caulk was applied to the two hour fire rated separation wall located between the nursing home and senior apartments.	
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect 80 out 163 residents. Findings include: On facility tour between 11:30 AM and 2:30 PM on 02/04/2013, observation revealed that the 2-hour fire rated building separation wall between	K 011	Fire rated caulk was applied on 2-6-13 by the St. John's Maintenance Department. The Maintenance Department will inspect the two hour fire rated separation walls every quarter and promptly correct any smoke barrier penetrations noted during the inspection. Written documentation of the inspection will be reviewed by the Environmental Services Supervisor (EVS) and kept on file at the facility. EVS will monitor for ongoing compliance.	

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K 011	Continued From page 3 the nursing home and the Knutson building on 1st floor has open penetration above the drop in ceiling tiles around several low voltage cables. NOTE: ALL building fire separation walls on both sides of wall shall be checked for unsealed penetrations.. This deficient practice was confirmed by the Facility Maintenance Director (SS) at the time of discovery.	K 011		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 A positive latch, a door coordinator, and an overlap astragal were installed on the activities room double door. A smoke gasket was also installed around the perimeter of the same door. The above installation was completed on 2-24-2013. The St. John's Environmental Services Supervisor will monitor the installation of all new doors.	

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K 018	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has corridor doors that do not latch into their frames in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect all 45 out 163 out residents. FINDINGS INCLUDE: On facility tour between 11:30 AM and 2:30 PM on 02/04/2013, observation revealed that the Activities room double doors (that opens into the corridor) were found to be as follows: 1. Do not have positive latching hardware 2. No door coordinator 3. Gap over 1/8 inch between double doors These deficient practices were confirmed by the Director of Maintenance (SS) at the time of discovery.	K 018		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and documentation review, the facility's general ventilating and air	K 067	K 067 A waiver is being requested and is attached to the plan of correction. Annual Waiver	

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K 067	Continued From page 5 conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 163 residents. Findings include: On facility tour between 11:30 AM and 2:30 PM on 02/04/2013, observation revealed, that the corridors in the 1960, 1964, and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous years. This deficient practice was confirmed by the Facility Maintenance Director (SS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, March 11, 2013 1:20 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Schroeder, Gary (DPS); 'scotspates@stjohnsofalbertlea.org'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: St Johns Lutheran Home (245338) K67 Annual Waiver Request

This is to notify you that St Johns Lutheran Home is requesting an annual waiver for K67, corridors as a plenum. The exit date was 2-7-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility	St. John's Lutheran Home, Albert Lea MN 56007	2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC section 9.2 and NFPA 90A, 1999 ED., because the corridors are being used as a plenum.	A waiver is being requested for K 067 A. Compliance will this provision will cause unreasonable hardship because: 1. The estimated cost of upgrading the facility's HVAC system to comply with NFPA 90A is $788,000. This estimate does not include: electrical, roofing, ceiling modifications, and mechanical design fees. 2. The ceiling tiles that would need to be removed to install required ductwork contain asbestos. The cost of abatement is difficult to estimate. Moreover, this would cause a significant hardship for residents and staff during abatement. B. There will be no adverse effect on the health and safety of the facility's residents and staff because: 1. The entire building is protected by a supervised automatic sprinkler system installed in accordance with NFPA 13. 2. The fire alarm system is an addressable system. 3. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. 4. Annual service and maintenance contracts are in place to insure that all of the fire protection systems are operational at all times. 5. The building fire alarm system is monitored to provide automatic fire department notification. 6. Fire safety training is provided to all employees on an annual basis and at orientation for new hires. 7. Fire drills are conducted at least quarterly on each shift. See additional information attached.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title ~~Fire Safety~~ Supervisor	Office State Fire Marshal	Date 3-11-13

C. St. John's master plan includes replacing the existing nursing home within the next five to six years. Replacement of the existing nursing home would happen in two phases.
   1. St. John's has applied to the Minnesota Department of Health (MDH) to build a new 84-bed nursing home. The new nursing home will enable St. John's to relocate over 50% of the residents residing at the current facility to the new facility. Contingent upon approval from MDH, construction of the new facility would begin within the next 12 months. The new nursing home would comply with NFPA 90A.
   2. Phase two of the master plan includes building a second new nursing home within the next five to six years. All residents at the existing site would be relocated to the new nursing home. This building would also be built to comply with NFPA 90A.