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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M8LL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00227

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245272**
2.STATE VENDOR OR MEDICAID NO.
(L2) **180482000**

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

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

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

6. DATE OF SURVEY **03/07/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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
	137			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SW Specialist 03/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/06/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5272

On 03/07/14, a Post Certification Revisit (PCR) was completed by the Department of Health =. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 01/17/14 standard survey, effective 02/20/14. Refer to the CMS 2567B for both health and life safety code.

Effective 02/20/14, the facility is certified for 137 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245272

April 10, 2014

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

Dear Ms. Barney:

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

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

Effective February 20, 2014, the above facility is certified for:

137 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 13, 2014

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

RE: Project Number S5272023

Dear Ms. Barney:

On February 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 17, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 7, 2014, the Minnesota Department of Health completed a Post Certification Revisit (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 January 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 17, 2014, effective February 20, 2014 and therefore remedies outlined in our letter to you dated February 3, 2014, 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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
245272	A. Building B. Wing	3/7/2014

Name of Facility	Street Address, City, State, Zip Code
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/20/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/20/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/20/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/20/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/20/2014**	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	GL/AK	03/14/2014	15507	03/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/17/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M8LL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00227

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

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

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

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

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

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

6. DATE OF SURVEY **01/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds 137 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HFE NE II 02/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/27/2014 (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
02/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5272
At the time of the January 17, 2014 health survey the facility was not in substantial compliance with Federal participation requirements. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). Post certification revisit to follow.

At the time of the January 20, 2014 life safety code (LSC) survey, the facility was in compliance with Federal participation requirements.

Please refer to the CMS-2567 for both health and life safety code findings along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8064

February 3, 2014

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

RE: Project Number S5272023

Dear Ms. Barney:

On January 21, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

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 February 26, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 April 17, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 17, 2014 (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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation 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	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	POC accepted JStanitto 2/18/14	

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

Jody Bar | Campus Administrator | 02/14/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the designated State agency (SA) and maintain evidence of a thorough investigation for 1 of 1 resident (R113) whose allegation of abuse was reviewed. Findings include: The facility did not immediately report an allegation of verbal abuse to the designated SA. Although the facility reportedly conducted an investigation into the allegation, evidence of a thorough investigation was not maintained. R113's quarterly Minimum Data Set (MDS) assessment dated 11/26/13 revealed diagnoses including Parkinson's disease and Alzheimer's disease. The assessment indicated the resident was cognitively intact. R113 reported in an interview on 1/13/14, at 4:27 p.m. that a male staff person abused her the	F 225	This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents' findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs F225 The facility reported the incident involving R113 to State Agency on 01/17/2014 and on 02/04/2014 the State Agency determined that no further action was necessary. The Vulnerable Adult – Abuse Prohibition Plan was reviewed and revised on 02/10/2014. The Administrator, DON & Director of Social Services will audit all Quality Input Forms (QIF), aka grievance reports, and Truthpoint Alerts (from our Truthpoint customer satisfaction surveys) to ensure investigation, notification and reporting to State Agency is completed per our revised policy. The facility will continue to investigate all potential maltreatment reports per our revised policy.	2/20/14

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F 225	Continued From page 2 previous night. The resident stated she reported the incident to the nurse manager and stated the facility was "handling it." R113 did not want to discuss the incident any further with surveyor. During further interview with R113 on 1/15/14, at 4:23 p.m. R113 reported she experienced three occasions where a male staff spoke loudly and shook his hand at the resident, quoting the Bible. R113 thought it had occurred in the evening after dinner and that other staff were present in the room. The resident again said she reported it to the nurse manager. A registered nurse manager (RN)-A was interviewed on 1/15/14, at 4:38 p.m. The RN stated R113 had made a report about three weeks prior, stating a male stood at the end of her bed and yelled at her in "a 'mean boss crack the whip' tone of voice." The resident could not recall what the person said to her. RN-A said she reported the resident's complaint to the administrator. RN-A reportedly interviewed the resident, but was unable to establish a time frame for the incident and attempted to have the resident identify potential male staff that had worked on the floor, however, the resident was unable to identify any staff person. A Truth Point Report dated 1/6/14, was reviewed on 1/15/14 and indicated under the area of concerns "[R113] to told Nurse Mgr that a NAR [manager that a nursing assistant/registered] was in her room several night before yelling at her in a tone that she described as 'letting me know who's boss.'" The follow-up dated 1/6/14 and 1/10/14, read "Interviewed [R113]. She was not able to state what was said by the NAR nor could she say who is was or at what time. Upon	F 225	Staff will be re-educated about the Vulnerable Adult – Abuse Prohibition Plan including investigation, notifying the administrator, and reporting to State Agency by 02/20/2014. Random staff audits will be performed by the Administrator or designee for three months to assure that staff understand the Vulnerable Adult – Abuse Prohibition Plan. A summary of the QIF and Truthpoint Alerts will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months to ensure the facility investigates all potential maltreatment reports per our revised policy. The recommendations from the Committee will be followed. The Administrator is responsible for compliance. RECEIVED FEB 18 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 225	Continued From page 3 investigation, I believe it could be the noc [night]shift and not the eve [evening] shift as originally thought. [Name of social worker] did f/u [follow-up] interview. [R113] told me she did not want to say too much because she wasn't sure if I was aware the SW [social worker] was talking to her. Reported to [name of director of nursing and administrator]. Plan to have 2 female caregivers and have a 2nd person be able to observe NAR/res. interactions. This will be on-going investigation. [R113] does not state she feels afraid to be here. [Name of living unit] NARs educated re appropriate behaviors to residents. SS[social services] interviewed resident twice about the incident, she would not go into any details more that what was told to the nurse manager. Confirmed not being afraid of the setting." The administrator stated in an interview on 1/16/14, at 2:12 p.m. on 1/16/14, she was made aware of R113 allegation on 1/6/14 reported to RN-A that the resident was yelled at in a tone letting her know who was boss. The resident said she was unable to verbalize what was said or that she was threatened or felt afraid. The administrator stated she and the DON screened the complaint as a potential customer service issue. The administrator stated if the resident stated she did not feel safe or was threatened a investigation would have been initiated and screening completed for outside agency reporting. A licensed social worker (LSW)-B on 1/16/14, at 2:29 p.m. stated she was aware of R113's allegation on 1/6/14. LSW-B stated R113 stated one of the aides came in and was loud and was very opinionated and let her know who was boss	F 225		

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F 225	Continued From page 4 and she felt she had to 'kick out' at the person. The LSW said at the resident's care conference on 1/16/14, R113 brought up the same thing that was reported on 1/6/14. Although resident could not recall the date, she reported the aide was loud and she had to kick her feet out to get him to back away. LSW-B further stated the resident again reported she did not feel threatened or afraid. The Vulnerable Adult Abuse Prohibition Plan dated 4/08, and revised on 10/13, indicated mandated reporters employed by the facility or providing services in the facility "shall report abuse, neglect, financial exploitation, comments made or overheard indicating possible abuse or physical injury sustained by a vulnerable adult that is not reasonable explained as soon as possible to the Common Entry Point [designated State agency] and Minnesota Department of Health" which included verbal abuse as the "use of oral, written or gestured language willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless to their age, ability to comprehend or disability." The administrator, director of nursing or the building charge would continue with the internal investigation of the reported allegation or incident. "The investigation may include interview of staff and written statements from staff involved in the incident, resident interviews, witnesses interviews and written statements of incident, environmental review, resident health status behavior review, medication review. If the administrator or director of nursing determines the internal report does not meet the criteria for reporting either under state or federal guidelines, the administrator, director of nursing, or designee will note that decision on the	F 225		

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F 225	Continued From page 5 Investigation of Potential Maltreatment form."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement policies and procedures regarding immediately reporting to the designated State agency (SA) and documentation of a thorough investigation for 1 of 1 resident (R113) whose allegation of verbal abuse was reviewed. Findings include: The facility did not immediately report an allegation of verbal abuse to the SA. Although the facility reportedly conducted an investigation into the allegation, evidence of a thorough investigation was not maintained. The facility's Vulnerable Adult Abuse Prohibition Plan dated 4/08 and revised 10/13, indicated mandated reporters employed by the facility or providing services in the facility "shall report abuse, neglect, financial exploitation, comments made or overheard indicating possible abuse or physical injury sustained by a vulnerable adult that is not reasonable explained as soon as possible to the Common Entry Point [designated	F 226	F226 The facility reported the incident involving R113 to State Agency on 01/17/2014 and on 02/04/2014 the State Agency determined that no further action was necessary. The Vulnerable Adult – Abuse Prohibition Plan was reviewed and revised on 02/10/2014. The Administrator, DON & Director of Social Services will audit all Quality Input Forms (QIF), aka grievance reports, and Truthpoint Alerts (from our Truthpoint customer satisfaction surveys) to ensure investigation, notification and reporting to State Agency is completed per our revised policy. The facility will continue to investigate all potential maltreatment reports per our revised policy. Staff will be re-educated about the Vulnerable Adult – Abuse Prohibition Plan including investigation, notifying the administrator, and reporting to State Agency by 02/20/2014. Random staff audits will be performed by the Administrator or designee for three months to assure that staff understand the Vulnerable Adult – Abuse Prohibition Plan.	2/20/14

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F 226	Continued From page 6 State agency] and Minnesota Department of Health" which included verbal abuse as the "use of oral, written or gestured language willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless to their age, ability to comprehend or disability." The administrator, director of nursing or the building charge would continue with the internal investigation of the reported allegation or incident. "The investigation may include interview of staff and written statements from staff involved in the incident, resident interviews, witnesses interviews and written statements of incident, environmental review, resident health status behavior review, medication review. If the administrator or director of nursing determines the internal report does not meet the criteria for reporting either under state or federal guidelines, the administrator, director of nursing, or designee will note that decision on the Investigation of Potential Maltreatment form." R113 at 4:27 p.m. on 1/13/14, she stated that a male staff person abused her the previous night. The resident stated she reported the incident to the nurse manager and stated the facility was "handling it." R113 did not want to discuss the incident any further with surveyor. During further interview with R113 on 1/15/14, at 4:23 p.m. R113 reported she experienced three occasions where a male staff spoke loudly and shook his hand at the resident, quoting the Bible. R113 thought it had occurred in the evening after dinner and that other staff were present in the room. The resident again said she reported it to the nurse manager. A registered nurse manager (RN)-A was	F 226	A summary of the QIF and Truthpoint Alerts will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months to ensure the facility investigates all potential maltreatment reports per our revised policy. The recommendations from the Committee will be followed. The Administrator is responsible for compliance.	

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F 226	Continued From page 7 interviewed on 1/15/14, at 4:38 p.m. The RN stated R113 had made a report about three weeks prior, stating a male stood at the end of her bed and yelled at her in "a 'mean boss crack the whip' tone of voice." The resident could not recall what the person said to her. RN-A said she reported the resident's complaint to the administrator. RN-A reportedly interviewed the resident, but was unable to establish a time frame for the incident and attempted to have the resident identify potential male staff that had worked on the floor, however, the resident was unable to identify any staff person. A Truth Point Report dated 1/6/14, was reviewed on 1/15/14 and indicated under the area of concerns "[R113] to told Nurse Mgr that a NAR [manager that a nursing assistant/registered] was in her room several night before yelling at her in a tone that she described as 'letting me know who's boss.'" The administrator stated on 1/16/14, at 2:12 p.m. on 1/16/14, she was made aware of R113's allegation. The administrator stated she and the DON screened the complaint as a potential customer service issue. The administrator stated if the resident stated she did not feel safe or was threatened a investigation would have been initiated and screening completed for outside agency reporting. The resident had not reported feeling threatened or afraid.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 8 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a catheter bag was covered in a manner that promoted the dignity of 1 of 3 residents (R85) whose catheter use was reviewed. Findings include: R85 was observed on 1/13/14, at 6:00 p.m. while in the dining room. Catheter tubing was exposed and touching the floor, and the catheter bag was in a pillowcase hanging from the back of the resident's wheelchair. The catheter was observed in the same manner on 1/13/14, at 9:00 a.m. on 1/15/14, at 2:00 p.m. and again on 1/16/14, at 9:43 a.m. R85's admission Minimum Data Set (MDS) assessment dated 11/28/13, revealed the resident had diagnoses including dementia and neurogenic bladder with the use of a catheter, and required extensive assist with activities of daily living and the use of a wheelchair. A registered nurse (RN)-A verified on 1/16/14, that R85's catheter was placed inside the pillowcase and tied to the back of the wheelchair. She also verified it was not the facility's usual practice to place a catheter bag inside a pillow case, as they normally used cloth bags. RN-A verified R85's catheter was not being stored in a manner than enhanced the resident's dignity. The facility's Catheter Care policy dated 9/13	F 241	F241 Proper catheter care was provided to R85 on the listed dates. However, the device that held the tubing was ineffective. On 1/17/2014, a catheter bag cover was placed on R85's catheter. To prevent reoccurrence with this issue with R85 and any other potential impacted residents, the facility ordered the Fig Leaf™ Urinary Drain Bags for residents with catheters on 02/11/2014. The Catheter Care Policy was reviewed and revised on 2/10/2014. Staff will be re-educated about the Catheter Care by 02/20/2014. For the next three months, facility will perform random Catheter Dignity Audits (at least 3 per month) for residents who have a catheter. The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	2/20/14

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F 241	Continued From page 9 directed staff to "Provide care to the individual who must use an indwelling catheter with care that meets the necessary standards of infection control and dignity. In addition it states the catheter bag must be placed in a bag holder."	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F272 An Admission & an Annual Bowel & Bladder Assessment was completed for R113 on 02/12/2014. A discussion of Risks and Benefits with resident and family was completed on 02/13/2014. A refusal of care form was completed with the resident and family on 02/13/2014. Facility is strongly recommending to resident and primary contact to make appointment with urologist for current status of need for catheter. Primary contact has agreed to make an appointment. All current residents who have a catheter will be audited to assure comprehensive assessment of use is in place and there is a continued need for a catheter. Bowel & Bladder assessments and care plans will be reviewed and revised as needed by 02/14/2014 The Nurse Managers and MDS Nurses will be reeducated on the facility bowel and bladder assessment policy by 02/20/2014.	2/20/14

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F 272	Continued From page 10 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use and continued need for an indwelling Foley catheter for 1 of 3 residents (R113) who were reviewed for catheter use. Findings include: The facility Bowel and Bladder Assessment policy dated 1/09, reviewed 4/10, directed staff to "Assess each resident for bowel and bladder incontinence and be evaluated for the feasibility in retraining bowel and bladder control upon admission, readmission, and annual reviews and with significant changes. Quarterly, the bowel and bladder assessment will be reviewed to ensure that the plan is appropriate for each resident." R113 was admitted with an indwelling Foley catheter in 1/13, and a comprehensive assessment of the continued need for the catheter was not completed at the time of the resident's admission. A registered nurse (RN)-A explained on 1/13/14, at 6:27 p.m. that R113 had been admitted with the catheter and had a diagnosis of mixed urinary incontinence. The RN said the resident and her	F 272	For the next three months, bowel & bladder assessments will be audited for any new catheter placements or resident who have a catheter upon admission. The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	

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F 272	Continued From page 11 family refused to have the catheter removed. R113 was observed and interviewed on 1/16/14, at 8:18 a.m. She had a urinary collection leg bag, which she reported had just been placed after a staff person disconnected the larger collection bag. The following day at 11:10 a.m. R113 was asked about the catheter and she said she did not know why she had the catheter. She stated, "That's a good question. I don't know if I like it. I have something a part of me that I don't know what it is for." A Bladder Assessment form, dated 1/18/13 read, "Has chronic indwelling Foley catheter related to neurogenic bladder due to Parkinson's. Staff care for it." R113's admission Minimum Data Set (MDS) dated 2/1/13, revealed diagnoses of arthritis, Parkinson's disease and indwelling Foley catheter, and the resident was identified as cognitively intact. Subsequent quarterly MDS assessments dated 5/30/13, 8/30/13, 11/26/13 noted the continued use of the catheter. An assessment dated 2/8/13 read, "Resident has chronic incontinence per NP [nurse practitioner] notes. Last change was 1/13/13. Has indwelling 20 FR [french] with 30 ml balloon. Hx of UTI's [urinary tract infections], fluids encouraged. Staff changes bags and empties, records outputs." NP notes revealed the following: 1) 3/18/13 "Urinary incontinence [UI]--combination of stress and urge with h/o recurrent UTI [history of urinary tract infections]...Has followed with urology in past and had chronic indwelling Foley catheter since	F 272		

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	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12 6/2011 d/t [due to] constant incontinence/being wet and foul odor associated with urine. 2) 4/9/13 As above with a note to "Obtain copy of urology notes for the record." No notes by a urologist were located in R113's medical record. 3) 11/6/13 "Urinary inconvenience--mixed, chronic, ? neurogenic component--long standing chronic Foley catheter, both patient and daughter adamantly against removing. Historically followed with urology. Foley cares daily. No recent UTI." RN-A reported on 1/16/14, at 12:10 p.m. she was unable to locate any further documentation related to the continued need for the catheter or a discussion of the risks and benefits of catheter use with R113 and her family.	F 272		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for personal hygiene for 2 of 3 residents (R318, R168) whose facial hair had not been removed. Findings include: R318's current care plan showed the resident had a self-care deficit related to a stroke and cognitive impairment. R19 required supervision and set up for oral care and extensive assist of one for grooming which included washing her face and	F 282	F282 On 01/17/2014 facial hair was removed from R318 and R168. Reviewed facility's ADL's AM Care Policy on 02/10/14. Staff re-education on ADL's AM Care Policy and grooming expectation will be completed by 02/20/2014. For the next three months, facility will randomly complete Grooming Audits (16 per month). The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	2/20/14

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F 282	Continued From page 13 dressing. R318 was observed on 1/13/14, at 6:00 p.m. and again on 1/16/14, at 7:26 a.m. The resident had un-removed facial hair. On 1/14/14, at 4:00 p.m. R318 explained that the staff helped her with toileting, washing her face, bathing, combing her hair and other personal needs. R318 stated she was unable to do it for herself because of a stroke. R168's care plan dated 7/29/13, identified the resident as requiring physical assistance for ADLs due to decreased strength and endurance, cognitive impairment and depression. Interventions directed staff to provide assistance of one with dressing, grooming, bathing and eating and encourage resident to participate as able. R168 was observed with untrimmed facial hair on 1/13/14, at 3:06 p.m. 1/14/14, at 3:28 p.m. and again on 1/16/14, at 7:53 a.m. when morning cares were observed. A nursing assistant (NA)-C assisted the resident to use the toilet, and to dress. At 7:58 a.m. (NA)-D entered the room to assist, as it was reported R168 had a history of refusing care. (NA)-E offered to set up oral care supplies so R168 could brush her teeth, however, the resident declined. The resident was then assisted to breakfast. She was not offered assistance to remove the facial hair. After the observations at 8:08 a.m. NA-E verified R168 required help with grooming, and the resident should have been offered assistance to remove the facial hair when it was present. During interview with a registered nurse (RN)-A at 10:40 a.m. on 1/17/14, she stated NA's should have removed residents' facial hair on bath day	F 282		

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F 282	Continued From page 14 and if the resident refused the nurse should have been notified. RN-A stated R168 required total assistance with removal of facial hair due to cognitive impairment.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide necessary care and services related to behaviors for 1 of 3 residents (R85) reviewed for behaviors. Findings include: R85's progress notes from 11/23/13 to 1/9/14, revealed the resident hit and kicked staff, two volunteers, and another resident. The resident's admission Minimum Data Set (MDS) assessment dated 11/28/13, indicated R85 had diagnoses including dementia with agitation and experienced hallucinations. The resident had daily behaviors directed towards others as well as behavioral symptoms not directed towards others 4-6 days during the assessment period. Those behaviors interfered with his cares and his participation in activities and put the resident at significant risk for physical illness/injury. The resident required	F 309	F309 R85 was seen by the Facility contracted psychologist and primary physician was notified of continuing behaviors. R85 interventions were discussed at Risk Management. R85's primary contact is agreeable to make an appointment with a psychiatrist and is in the progress of doing so. IDT will identify residents, including R85, who display behaviors that interfere with cares, participation in activities, and/or put the resident at significant risk for illness/injury. A task in Point of Care, our electronic medical record, will be set up so that staff can document target behaviors, interventions attempted and the effectiveness of the interventions. We will discuss this findings at our Risk Management Meeting. The Behavior Monitoring/Side Effects Monitoring Policy was reviewed on 2/10/2014. Staff re-education on Behavior Monitoring/Side Effects Monitoring completed by 02/20/2014. For the next three months, facility will randomly complete Behaviors Monitoring audit (3 per month).	2/20/14

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F 309	Continued From page 15 extensive assist with activities of daily living. R85's family member (F)-A was interviewed on 1/17/14, at 8:30 a.m. and stated she was aware the resident was exhibiting daily behaviors towards others, but did not want the resident's medication regimen changed and did not want the resident seen by a psychiatrist. The care plan revised on 12/2/13, addressed an alteration in behavior due to depression, cognitive impairment, and dementia with physical abusive behaviors directed towards others. The goal was for the resident to interact with staff and other residents in a calm and safe manner. Approaches included administering medication as ordered and monitoring for its efficacy, allow the resident choices throughout the day, approach the resident quietly with a friendly manner (and at an angle from the side, more than his arm length away), "explain what you want to do for him and remind him not to strike out or kick before moving closer. Explain all procedures before starting." A registered nurse (RN)-A stated in an interview on 1/16/14, at 12:30 p.m. that although the resident had exhibited aggressive behavior toward staff, two volunteers, and another resident, they had not contacted the physician regarding the problem. The resident's family did not want R85's medications Seroquel (antipsychotic), Depakote (anticonvulsant commonly used to manage behavior), and Zoloft (antidepressant) changed due to a reported history of dose reduction failure, and did not want the resident seen by a psychiatrist. Non-pharmacological interventions included 1:1 staff interaction, and explaining cares to the resident while performing personal care. The RN	F 309	The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	

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F 309	Continued From page 16 stated that the team had not discussed the effectiveness or non-effectiveness of those interventions. On 1/16/14, at 1:01 p.m. a licensed practical nurse (LPN)-A reported she had observed R85 hitting another resident, and had unpredictable behaviors towards others. LPN-A also stated the family did not want the resident's medication changed. The LPN was unsure whether the physician had been apprised of R85's behavioral status.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to provide assistance with personal hygiene care for 2 of 3 residents (R318, R168) in the sample who were reviewed for activities of daily living (ADLs) and were dependent on staff for grooming. Findings include: R318 was observed with un-removed facial hair on 1/13/14, at 6:00 p.m. On 1/14/14, at 4:00 p.m. R318 explained that the staff helped her with toileting, washing her face, bathing, combing her hair and other personal needs. R318 stated she	F 312	F312 On 01/17/2014 facial hair was removed from R318 and R168. Reviewed facility's ADL's AM Care Policy on 02/10/14. Staff re-education on ADL's AM Care Policy and grooming expectation will be completed by 02/20/2014. For the next three months, facility will randomly complete Grooming Audits (16 per month). The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	2/20/14

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F 312	Continued From page 17 was unable to do it for herself because of a stroke. Again on 1/16/14, at 7:26 a.m. the resident had un-removed facial hair. R318's current care plan showed the resident had a self-care deficit related to a stroke and cognitive impairment. R19 required supervision and set up for oral care and extensive assist of one for grooming which included washing her face and dressing. R168 was observed with un-removed facial hair on 1/13/14, at 3:06 p.m. 1/14/14, at 3:28 p.m. and again on 1/16/14, at 7:53 a.m. when morning cares were observed. A nursing assistant (NA)-C assisted the resident to use the toilet, and to dress. At 7:58 a.m. (NA)-D entered the room to assist, as it was reported R168 had a history of refusing care. NA-C offered to set up oral care supplies so R168 could brush her teeth, however, the resident declined. The resident was then assisted to breakfast. She was not offered assistance to remove the facial hair. After the observations at 8:08 a.m. (NA)-E verified R168 required help with grooming, and the resident should have been offered assistance to remove the facial hair when it was present. R168's quarterly MDS dated 10/24/13, indicated the resident required extensive assistance of one staff to perform personal hygiene. Her care plan dated 7/29/13, identified the need for physical assistance for activities of daily living due to decreased strength and endurance, cognitive impairment and depression. The interventions directed staff to provide assistance with dressing, grooming, bathing and eating and encourage resident to participate as able.	F 312		

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F 312	Continued From page 18 A registered nurse (RN)-A stated on 1/17/14, at 10:40 a.m. that the NAs should have removed the resident's facial hair on bath day and if she refused the nurse should have been informed. The RN explained that R168 was dependent on staff to remove the facial hair due to cognition issues. The ADLs AM [morning] Cares policy dated 1/09 and revised 12/13, directed staff to shave residents as needed.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide justification for the continued need for an indwelling Foley catheter for 1 of 3 residents (R113) and to ensure appropriate care and services to minimize the risk for urinary tract infections for 1 of 3 residents (R85) reviewed for catheter use. Findings include:	F 315	F315 An Admission & an Annual Bowel & Bladder Assessment was completed for R113 on 02/12/2014. A discussion of Risks and Benefits with resident and family was completed on 02/13/2014. A refusal of care form was completed with the resident and family on 02/13/2014. Facility is strongly recommending to resident and primary contact to make appointment with urologist for current status of need for catheter. Primary contact has agreed to make an appointment. Proper catheter care was provided to R85 on the listed dates. However, the device that held the tubing was ineffective. On 1/17/2014, a catheter bag cover was placed on R85's catheter.	2/20/14

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F 315	Continued From page 19 R113 was admitted with an indwelling Foley catheter in 1/13, and no attempts at removal of the catheter were made or justification provided for its continued use. R113 was observed and interviewed on 1/16/14, at 8:18 a.m. She had a urinary collection leg bag, which she reported had just been placed after a staff person disconnected the larger collection bag. The following day at 11:10 a.m. R113 was asked about the catheter and she said she did not know why she had the catheter. She stated, "That's a good question. I don't know if I like it. I have something a part of me that I don't know what it is for." A registered nurse (RN)-A explained on 1/13/14, at 6:27 p.m. that R113 had been admitted with the catheter and had a diagnosis of mixed urinary incontinence. The RN said the resident and her family refused to have the catheter removed. R113's admission Minimum Data Set (MDS) dated 2/1/13, revealed diagnoses of arthritis, Parkinson's disease and indwelling Foley catheter. Subsequent quarterly MDS assessments dated 5/30/13, 8/30/13, 11/26/13 noted the continued use of the catheter. Although the 11/26/13 MDS noted a diagnosis of Alzheimer's disease, the resident was identified as being cognitively intact. A Bladder Assessment form, dated 1/18/13 read, "Has chronic indwelling Foley catheter related to neurogenic bladder due to Parkinson's. Staff care for it." An assessment dated 2/8/13 read, "Resident has chronic incontinence per NP [nurse practitioner] notes. Last change was 1/13/13.	F 315	All current residents who have a catheter will be audited to assure comprehensive assessment of use is in place and there is a continued need for a catheter. Bowel & Bladder assessments and care plans will be reviewed and revised as needed by 02/14/2014 To prevent reoccurrence with this issue with R85 and any other potential impacted residents, the facility ordered the Fig Leaf™ Urinary Drain Bags for residents with catheters on 02/11/2014. The Nurse Managers and MDS Nurses will be reeducated on the facility bowel and bladder assessment policy by 02/20/2014. The Catheter Care Policy was reviewed and revised on 2/10/2014. Staff will be re-educated about the Catheter Care by 02/20/2014. For the next three months, bowel & bladder assessments will be audited for any new catheter placements or resident who have a catheter upon admission. For the next three months, facility will perform random Catheter Dignity Audits (at least 3 per month) for residents who have a catheter.	

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F 315	Continued From page 20 Has indwelling 20 FR [french] with 30 ml balloon. Hx of UTI's [urinary tract infections], fluids encouraged. Staff changes bags and empties, records outputs." The quarterly bowel and bladder review dated 11/26/13, indicated R113's care plan was current and no changes were required. The care plan dated 1/25/13, indicated R113 had a catheter related to constant incontinence according to the NP. The goal was for the resident to be free from complications, infection, skin problems, device failure or blockage. The interventions directed staff to observe for and assist resident with dietary and/or fluid requirements, monitor for signs of UTI or blockage, change device as ordered by physician. NP notes revealed the following: 1) 3/18/13 "Urinary incontinence [UI]--combination of stress and urge with h/o recurrent UTI [history of urinary tract infections]...Has followed with urology in past and had chronic indwelling Foley catheter since 6/2011 d/t (due to) constant incontinence/being wet and foul odor associated with urine. 2) 4/9/13 As above with a note to "Obtain copy of urology notes for the record." No notes by a urologist were located in R113's medical record. 3) 11/6/13 "Urinary inconvenience--mixed, chronic, ? neurogenic component--long standing chronic Foley catheter, both patient and daughter adamantly against removing. Historically followed with urology. Foley cares daily. No recent UTI." RN-A reported on 1/16/14, at 12:10 p.m. she was unable to locate any further documentation related to the continued need for the catheter or a discussion of the risks and benefits of catheter	F 315	The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	

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F 315	Continued From page 21 use with R113 and her family. The facility Bowel and Bladder Assessment policy dated 1/09, reviewed 4/10, directed staff to "Assess each resident for bowel and bladder incontinence and be evaluated for the feasibility in retraining bowel and bladder control upon admission, readmission, and annual reviews and with significant changes. Quarterly, the bowel and bladder assessment will be reviewed to ensure that the plan is appropriate for each resident." Findings include: R85 was observed on 1/13/14, at 6:00 p.m. while in the dining room. Catheter tubing was exposed and was touching the floor, and the catheter bag was in a pillowcase and was hanging from the back of the resident's wheelchair. At 7:00 p.m. the catheter tubing was dragging on the floor as a family member pushed R85 back to his room. During subsequent observations the tubing was consistently touching the floor on 1/13/14, at 9:00 a.m. on 1/15/14, at 2:00 p.m. and again on 1/16/14, at 9:43 a.m. R85's admission Minimum Data Set (MDS) assessment dated 11/28/13 revealed diagnoses including neurogenic bladder, and the resident utilized a suprapubic catheter, required extensive assist with activities of daily living, and used a wheelchair. RN-A stated on 1/16/14 that R85's catheter was placed inside the pillowcase and tied to the back of the wheelchair. She confirmed the tubing was dragging on the floor and verified that the resident had experienced two urinary tract infections	F 315		

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F 315	Continued From page 22 (UTIs) since his admission less than two months prior. It was confirmed in R85's record he had been diagnosed with a UTI on 11/29/13, and again on 1/2/13, and had been prescribed the antibiotic Macrobid for the infection. The facility's Catheter Care policy dated 9/13, directed staff to "Provide care to the individual who must use an indwelling catheter with care that meets the necessary standards of infection control and dignity...catheter bag must be placed in a bag holder."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	F329 R85 was seen by the Facility contracted psychologist and primary physician was notified of continuing behaviors. R85 interventions were discussed at Risk Management. R85's primary contact is agreeable to make an appointment with a psychiatrist and is in the progress of doing so. Began monitoring of R85 orthostatic blood pressure. IDT will identify residents, including R85, who are on a psychoactive medication. A task in Point of Care, our electronic medical record, will be set up so that staff can document target behaviors, interventions attempted and the effectiveness of the interventions. We will discuss this findings at our Risk Management Meeting.	2/20/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure follow through with a pharmacy recommendation for 1 of 5 residents (R85) reviewed for unnecessary medications. Findings include: R85's pharmacy review dated 12/12/13, revealed physician orders for the antipsychotic medication Seroquel 200 milligrams (mg) in the evening and 50 mg in the morning to aid with dementia with behaviors. The physician recommended keeping the current dose due to a prior psychiatrists recommendations. The pharmacist also noted the resident displayed behaviors of striking at staff and yelling out, and had experienced two falls on 11/30/13 and 12/6/13. "Thee maximum recommended dosage is 200 mg per day. The use of this agent is not recommended unless behaviors are harmful to self or others, and interventions are shown not to be effective or redirected. Please provide documentation to support this high dose and if possible, please reduce the dose slightly. Would recommend monitoring orthostatic blood pressure [measuring lying, sitting, standing to determine a potential drop in pressure known to contribute to falls] once a month to ensure he is tolerating the medication." R85's admission Minimum Data Set (MDS) assessment dated 11/28/13, indicated R85 had diagnoses including dementia with agitation and experienced hallucinations. The resident had daily behaviors directed towards others behavioral symptoms not directed towards others	F 329	The Behavior Monitoring/Side Effects Monitoring Policy and the Psychopharmacologic Drug Use Policy was reviewed on 2/10/2014. Staff re-education on Behavior Monitoring/Side Effects Monitoring and Psychopharmacologic Drug Use completed by 02/20/2014. For the next three months, facility will randomly complete Behaviors Monitoring and Psychopharmacologic Drug Use audits (3 per month). The results of the audits will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Director of Nursing is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 4-6 days during the assessment period. Those behaviors interfered with his cares and his participation in activities, and put the resident at significant risk for physical illness/injury. The resident required extensive assist with activities of daily living. A registered nurse (RN)-A was interviewed on 1/16/14, at 12:30 p.m. and explained R85 exhibited behaviors towards staff, two volunteers, and another resident. In addition to the Seroquel, the resident was prescribed Depakote (anticonvulsant medication commonly used to manage behavior) and Zoloft (antidepressant), and R85's family did not want the regimen changed due to a history of failed dose reductions. The RN stated they had not followed the pharmacist's recommendation to take R85's orthostatic blood pressure monthly. On 1/16/14, at 1:01 p.m. a licensed practical nurse (LPN)-A reported she had observed R85 hitting another resident, and had unpredictable behaviors towards others. LPN-A also stated the family did not want the resident's medication changed. The LPN was unsure whether the physician had been apprised of R85's behavioral status. R85's family member (F)-A was interviewed on 1/17/14, at 8:30 a.m. and stated she was aware the resident was exhibiting daily behaviors towards others and she did not want the resident's medication regimen changed and did not want the resident seen by a psychiatrist.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 25 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required actual hours worked by nursing staff in the facility. This practice had the potential to affect the 129 residents residing in the facility and visitors. Findings include: On 1/13/14, at 11:50 a.m. during the initial facility	F 356	F356 Martin Luther Care Center's posted Nurse Staff Information was revised on 02/11/14 to include the start and end times of the shifts to indicate actual hours worked for licensed and unlicensed nursing staff. The facility will continue to post the form near the reception desk. The Administrator or designee will audit for one month to ensure accuracy of posting. The results of the audit will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Administrator is responsible for compliance.	2/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 26 tour, the Martin Luther Care Center Nursing Home Hours Report of Nursing Staff Directly Responsible for Resident Care dated 1/13/14, was observed posted in the front entry on the wall adjacent to the receptionist desk. The form identified the number of licensed staff including registered nurses and licensed practical nurses and unlicensed nursing staff including nursing assistants and trained medication aides, number of hours each worked and identified the shift as Days, Evenings and Nights. The posting, however, lacked documentation of the actual hours worked by the licensed and unlicensed nursing staff. On 1/17/14, review of postings dated 1/13/14 through 1/17/14, revealed all lacked documentation of the actual hours worked by the staff at the facility. When interviewed on 1/17/14, at 12:20 p.m. the administrator confirmed the actual hours worked for licensed and unlicensed nursing staff for each shift was not identified on the daily posting. The administrator further stated she was unaware that the actual hours worked needed to be posted and the facility did not have a policy specifically pertaining to the nursing staffing posting.	F 356		
F 465 SS=E	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	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 27 by: Based on observation, interview, and document review, the facility failed to provide an environment in good repair related to resident room doors for 6 of 42 residents (R258, R61, R168, R148, R220, R198) on the Eagle Crest unit. Findings include: A tour of the environment was conducted on 1/16/14, at 12:00 p.m. with the director of environmental services, the facilities director and the administrative intern. During the tour four room doors on the Eagle Crest unit had marred wood along the bottom half of the door. The wood was exposed resulting in some sharp edges and possible splintering. The marring created an un-cleanable surface. The facilities director explained that wood putty had not held along the edge of the doors, but edge protectors were available that could have been placed on the doors. He stated that the doors were not inspected as part of their preventive maintenance plan, but environmental rounds were conducted quarterly, and a new checklist had just been initiated. The process was to review each corridor once per quarter and sample two rooms, looking for trends. He verified that the doors had not been reported as a potential safety hazard or in need of maintenance. The facility policy for safety inspection dated 2006, indicated that the inspection encompassed all areas of the facility and was to be conducted quarterly. Upon completion of the inspection an action plan was to be developed to correct	F 465	F465 The four doors listed were repaired on 01/16/2014 An audit will be completed on all doors to ensure they are in good repair by 02/14/2014. We will continue our practice of quarterly environmental rounds. Staff re-education on completion of work orders will be completed by 02/20/2014.The Director of Maintenance or designee will complete random audits on the doors to ensure they are in good repair (10 per month). The results of the audit will be reported to the QAPI Committee and the Committee's recommendations will be followed. The Administrator is responsible for compliance.	2/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	01/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 28 non-compliant items.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/21/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Martin Luther Manor, 1984 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Martin Luther Manor is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building.

The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 131 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

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

#5272022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **03 - NEW RESIDENCE** B. WING _____	**01/21/2014**

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

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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Martin Luther Manor, 2010 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

Martin Luther Manor is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building.

The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 125 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

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.

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

F5272022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **04 - ADMINISTRATION AND ASSEMBLY** B. WING _____	**01/21/2014**

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

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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Martin Luther Manor, 2011 Building, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

Martin Luther Manor is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) construction building was completed in 2010 and a 1-story, Type II (000) construction building was completed in 2011. As the original construction and new construction(s) are incompatible, the facility is surveyed as three buildings, 1984 Building, 2010 Building and 2011 Building.

The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The 2010 building also has resident room smoke detection. The facility has a capacity of 137 beds and had a census of 125 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8064

February 3, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5272023

Dear Ms. Barney:

The above facility was surveyed on January 13, 2014 through January 17, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

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 me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File