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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4G7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245407**
2.STATE VENDOR OR MEDICAID NO.
(L2) **346740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/07/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 05/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/20/2016 (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
11/01/1988
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 19, 2016

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: Project Number S5407024

Dear Mr. Jensen:

On April 7, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 May 17, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 July 7, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 7, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint #H5407009 was completed and found not to be substantiated.	F 000		
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	F 225		5/17/16

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

Electronically Signed | 04/28/2016

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F 225	Continued From page 1 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 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 notify the administrator and the State Agency (SA) and thoroughly investigate an alleged violation of neglect for 1 of 1 resident (R78) reviewed during closed record who left the premises without staff knowledge. Findings include: R78 was admitted on 11/17/15, with diagnoses identified on the history and physical form dated 11/15/15, which included: early dementia, peripheral neuropathy and low back pain from	F 225	It is the policy of St. John Lutheran Home to immediately notify the Administrator and State Agency and thoroughly investigate an alleged violation of neglect. Resident R78 has expired. St. John Lutheran Home will continue to immediately report to the Administrator and the State Agency, and thoroughly investigate any alleged violations of potential abuse, neglect, or maltreatment. The facility will incorporate an	

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F 225	Continued From page 2 bone metastases. R78 expired on 2/16/16. Review of an incident report for R78 dated 11/22/15, at 3:40 p.m. indicated R78 walked from the nursing home to the Maples assisted living (AL) center across the street (where the resident had previously lived prior to admission) after attending a scheduled activity. The staff had not been aware R78 was missing until AL staff returned R78 to the facility. Interventions listed to prevent further occurrence were: assist R78 to the activity and return the resident to her room. No further information was provided. Review of the admission preliminary care plan identified R78 with dementia, short term memory impairment, anxiety, wandering and requires frequent staff reminders. The care plan identified R78 as having alteration in mobility related to dementia, anxiety, impulsiveness, wandering potential and a history of falls. Interventions listed were: supervise and escort the R78 back and forth to activities when off the station. Review of the admission Minimum Data Set (MDS) dated 11/25/15, identified R78 with a Brief Interview for Mental Status (BIMS) of 10/15, indicating moderately impaired cognitive ability. The assessment further indicated R78 wanders and puts the resident at significant risk of getting to a potentially dangerous place. The resident requires support of 1 assistance related to locomotion on the unit and requires the use of a walker for mobility. The MDS further identified that R78 had a fall since admission. Review of the Care Area Assessment (CAA) dated 11/25/15, included diagnoses of Alzheimer's disease or other dementia, impaired	F 225	investigation report for any suspected vulnerable adult maltreatment and/or abuse The facility will audit all VA reports submitted to the State Agency for relevant information up to 6 reports submitted. Social Services will report on any findings to the quarterly QA & A committee. Social Services will be responsible for monitoring compliance	

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F 225	Continued From page 3	F 225		

decision making, slow occurring cognitive decline and lack of reorientation with reminders. Wandering occurring at least 1 day in the past 7 days, not recognizing the environment or misinterpreting the environment or actions of others. The CAA further indicated R78 had been having difficulty understanding and recalling where she lives due to her new admission and dementia. The CAA further included R78 left the building and walked to the Maples AL center (located across the parking lot/street from the facility) after an activity. Resident does require supervision.

Review of admission progress notes dated 11/17/15, identified R78 as requiring assistance of staff and a walker with ambulating and transfers. The notes further included R78 was confused to location and why she was at the nursing facility. Notes indicated R78 wandered to another nurse's station and had to be redirected multiple times throughout the evening. Progress notes dated 11/15, indicated she had fallen after losing her balance and progress notes dated 11/19/15, indicated R78 fell and hit her head when bending down to pick up a piece of paper.

Interview with licensed practical nurse (LPN)-C on 4/4/16, at 2:25 p.m. indicated she was the nurse on duty when R78 left the building. LPN-C stated a staff member brought R78 back from the Maples assisted living center but she was not aware of the length of time she was gone from the premises. LPN-C confirmed she did not interview the AL staff who returned R78. LPN-C indicated staff were instructed to watch R78's whereabouts closer.

Interview with licensed social worker (LSW)-A on

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F 225	Continued From page 4	F 225		

4/5/16, at 2:37 p.m. indicated the facility chose not to report to the SA after R78 left the building because the interdisciplinary team (IDT) felt this was not an elopement since it was isolated. LSW-A indicated R78 had been back and forth to the nursing facility many times to visit while living at the Maples AL. LSW-A verified there was no documentation in the R78's medical record related to this discussion nor was there documentation indicating an investigation had been completed.

Interview with nursing assistant (NA)-D on 4/7/16, at 11:52 a.m. indicated she was assigned to care for R78 the day she left the facility. NA-D confirmed R78 was confused prior to the incident but was unable to recall who returned the resident from the Maples AL nor how long R78 had been off the premises.

When interviewed on 4/7/16, at 9:17 a.m. the director of nursing (DON) and LSW-A indicated they had been aware that R78 left the premises on 11/22/15, but felt it was isolated and R78 was aware of where she was going as she walked to the AL to retrieve her clock. Both staff confirmed there was no documentation nor investigation to confirm any follow-up had been occurred and to substantiate this claim.

Interview with LSW-A on 4/7/16, at 1:15 p.m. confirmed the facility did not follow their policies and did not report the incident as they thought it was not reportable. Although R78 was identified in the medical record as being confused to her whereabouts and required assistance with safe mobility, the facility felt this was not a reportable event.

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F 225	Continued From page 5 Review of the facility's Wandering Resident/Elopement Policy dated 8/2011, included: (1) the intake registered nurse (RN) or Social Service Department will do the initial screening for wandering/elopement risk when gathering initial intake information; (2) during the admission process if risk is determined, this will be communicated with the nursing staff and placed on the resident plan of care; (3) upon discovery of the [missing] resident, assess the resident physical condition, and obtain medical assistance if needed. Complete reports to the Office of Health Facility Complaints (OHFC) office. Review of the facility's Vulnerable Adult Policy dated 9/2013, included: the facility must ensure 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 State survey and certification agency). 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 the State Survey and Certification Agency, and Common Entry Point) within 5 working days of the incident, and if the alleged violation is verified, appropriate action must be taken.	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	F 226		5/17/16

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F 226	Continued From page 6 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their Abuse/Neglect policy to ensure immediate reporting of an allegation of potential neglect to the administrator and the State Agency (SA) and to conduct a thorough investigation for 1 of 1 resident (R78) reviewed during closed record who left the premises without staff knowledge. Findings include: Review of the facility's Vulnerable Adult Policy dated 9/2013, included: the facility must ensure 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 State survey and certification agency). 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 the State Survey and Certification Agency, and Common Entry Point) within 5 working days of the incident, and if the alleged violation is verified, appropriate action must be taken. Review of the facility's Wandering Resident/Elopement Policy dated 8/2011, included: (1) the intake registered nurse (RN) or Social Service Department will do the initial	F 226	It is the policy of St. John Lutheran Home to implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Resident R78 has expired St. John Lutheran Home will review and revise its vulnerable adult policy and procedures that prohibit mistreatment, neglect, abuse and misappropriation of property of its residents. The facility will immediately report an allegation of potential maltreatment to the Administrator and the State Agency. A thorough investigation will be conducted and reported within five working days of the incident. The facility Resident Elopement Policy and procedure will be reviewed and revised to include the following: - Initial Screening for wandering/elopement risk - Care Planning and communication to nursing staff if a risk has been determined - Discovery of elopement and search procedure - Reporting Process - Investigation and evaluation of any occurrence	

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	245407	A. BUILDING _____ B. WING _____	04/07/2016

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F 226	Continued From page 7 screening for wandering/elopement risk when gathering initial intake information; (2) during the admission process if risk is determined, this will be communicated with the nursing staff and placed on the resident plan of care; (3) upon discovery of the [missing] resident, assess the resident physical condition, and obtain medical assistance if needed. Complete reports to the Office of Health Facility Complaints (OHFC) office. R78 was admitted on 11/17/15, with diagnoses identified on the history and physical form dated 11/15/15, which included: early dementia, peripheral neuropathy and low back pain from bone metastases. R78 expired on 2/16/16. Review of an incident report for R78 dated 11/22/15, at 3:40 p.m. indicated R78 walked from the nursing home to the Maples assisted living (AL) center across the street (where the resident had previously lived prior to admission) after attending a scheduled activity. The staff had not been aware R78 was missing until AL staff returned R78 to the facility. Interventions listed to prevent further occurrence were: assist R78 to the activity and return the resident to her room. No further information was provided. Review of the admission preliminary care plan identified R78 with dementia, short term memory impairment, anxiety, wandering and requires frequent staff reminders. The care plan identified R78 as having alteration in mobility related to dementia, anxiety, impulsiveness, wandering potential and a history of falls. Interventions listed were: supervise and escort the R78 back and forth to activities when off the station.	F 226	- Updating the care plan with any interventions The facility will provide education to all staff on elopement policy and procedures and incident reporting. Any incidents of elopement will be reported to the QA & A committee. The Director of Nursing (or designee) and Social Services will be responsible for ongoing compliance	

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Review of the admission Minimum Data Set (MDS) dated 11/25/15, identified R78 with a Brief Interview for Mental Status (BIMS) of 10/15, indicating moderately impaired cognitive ability. The assessment further indicated R78 wanders and puts the resident at significant risk of getting to a potentially dangerous place. The resident requires support of 1 assistance related to locomotion on the unit and requires the use of a walker for mobility. The MDS further identified that R78 had a fall since admission.

Review of the Care Area Assessment (CAA) dated 11/25/15, included diagnoses of Alzheimer's disease or other dementia, impaired decision making, slow occurring cognitive decline and lack of reorientation with reminders. Wandering occurring at least 1 day in the past 7 days, not recognizing the environment or misinterpreting the environment or actions of others. The CAA further indicated R78 had been having difficulty understanding and recalling where she lives due to her new admission and dementia. The CAA further included R78 left the building and walked to the Maples AL center (located across the parking lot/street from the facility) after an activity. Resident does require supervision.

Review of admission progress notes dated 11/17/15, identified R78 as requiring assistance of staff and a walker with ambulating and transfers. The notes further included R78 was confused to location and why she was at the nursing facility. Notes indicated R78 wandered to another nurse's station and had to be redirected multiple times throughout the evening. Progress notes dated 11/15, indicated she had fallen after losing her balance and progress notes dated

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11/19/15, indicated R78 fell and hit her head when bending down to pick up a piece of paper.

Interview with licensed practical nurse (LPN)-C on 4/4/16, at 2:25 p.m. indicated she was the nurse on duty when R78 left the building. LPN-C stated a staff member brought R78 back from the Maples assisted living center but she was not aware of the length of time she was gone from the premises. LPN-C confirmed she did not interview the AL staff who returned R78. LPN-C indicated staff were instructed to watch R78's whereabouts closer.

Interview with licensed social worker (LSW)-A on 4/5/16, at 2:37 p.m. indicated the facility chose not to report to the SA after R78 left the building because the interdisciplinary team (IDT) felt this was not an elopement since it was isolated. LSW-A indicated R78 had been back and forth to the nursing facility many times to visit while living at the Maples AL. LSW-A verified there was no documentation in the R78's medical record related to this discussion nor was there documentation indicating an investigation had been completed.

Interview with nursing assistant (NA)-D on 4/7/16, at 11:52 a.m. indicated she was assigned to care for R78 the day she left the facility. NA-D confirmed R78 was confused prior to the incident but was unable to recall who returned the resident from the Maples AL nor how long R78 had been off the premises.

When interviewed on 4/7/16, at 9:17 a.m. the director of nursing (DON) and LSW-A indicated they had been aware that R78 left the premises on 11/22/15, but felt it was isolated and R78 was

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F 226	Continued From page 10 aware of where she was going as she was retrieving a clock in the AL. Both staff confirmed there was no documentation nor investigation to confirm any follow-up had been occurred. Interview with LSW-A on 4/7/16, at 1:15 p.m. confirmed the facility did not follow their policies and did not report the incident as they thought it was not reportable.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan to	F 280	It is the policy of St. John Lutheran Home to develop a comprehensive care plan	5/17/16

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F 280	Continued From page 11 include all identified interventions for 1 of 3 residents (R29) reviewed for accidents and for 1 of 3 residents (R29) reviewed for pain. Findings include: R29 had diagnoses that included: dementia with behaviors, Alzheimer's disease, fall history, and depression. R29's quarterly Minimum Data Set (MDS) assessment, dated 1/3/16, identified R29 required extensive assistance of two with bed mobility and transfers. The MDS further identified R29 with a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. The facility failed to revise the care plan to identify whether R29 was to utilize the electric reclining chair remote control or not so that R29 remained safe while resting in this chair. On 4/4/16, at 5:18 p.m. it was observed that R29 was sitting in an electric recliner located in the first floor day room. The remote (which controls the up and down motion of recliner) was noted lying on the floor, adjacent to the chair but not within R29's reach. On 4/5/16, from 3:11 p.m. to 4:19 p.m. R29 was observed seated in the electric recliner chair located in the first floor dayroom; R29 was in a reclined position and the remote control was tucked behind the chair, not within reach. On 4/6/16, at 9:49 a.m. R29 was again observed to be seated in first floor day room electric recliner chair. The remote control for this chair was not within reach. On 4/7/16 at 9:14 a.m. R29 was observed sitting in the electric recliner chair located in the first floor day room. The remote control for the electric chair was placed next to R29, operational and within reach. When interviewed on 4/6/16, at 9:55 a.m. registered nurse (RN)-A stated R29 would "fiddle" with the remote control which operated the	F 280	within 7 days after the completion of the comprehensive assessment. The care plan for resident R29 has been updated to address complaints of pain and safety precautions and to include the use of the remote control while electric recliner. Staff have been educated on the revised care plan. Audits will be performed by the Director of Nursing or designee weekly for 6 weeks to ensure updates to residents comprehensive care plans are complete. The results of the audits will be reported to the QA & A committee for review and recommendations. Ongoing compliance will be monitored by the Director of Nursing or designee.	

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F 280	Continued From page 12	F 280		

electric recliner chair and could potentially fall from this recliner if it was raised too high. RN-A stated she was not sure when staff had initiated removing the remote from R29's access but thought that it was a good plan to prevent R29 from falling from the recliner.

When interviewed on 4/7/16, at 9:14 a.m. NA-C identified she had transferred R29 into the first floor day room recliner with the assistance of NA-A. NA-C stated she was not sure whether the remote control for the chair should be accessible for R29 to operate or not. NA-A stated R29's care plan lacked direction indicating whether the remote control should be accessible or not for R29 to use.

On 4/7/16, at 9:40 a.m. the director of nursing (DON) stated, "They don't know what to do", in reference to the direct care staff and R29's use of the remote to operate the electric recliner chair. The DON verified the active care plan lacked any problems, goals, and/or interventions related to the use of remote control while R29 rests in the electric recliner. The DON verified the care plan should have been revised to include the use/restriction of the remote to operate the recliner as this could be a safety concern for R29 if utilized inappropriately.

R29's care plan, dated, 1/12/16 identified R29 at high risk for falling related to weakness, dementia with behaviors, depression, poor balance, need for assistance with transfers and ambulation. The care plan further identified R29 having history of restlessness and nervousness. R29's interventions identified in the care plan to reduce fall risk included:

1. Extensive assist of one to two staff for all transfers.
2. Extensive assist of two staff and use of walker with ambulation.

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F 280	Continued From page 13 3. Ambulate with two assist and walker as needed if resident chooses. 4. Medicate for pain. 5. Encourage resident to eat meals to maintain strength. 6. Defined perimeter mattress on bed and fall mat on floor beside bed. 7. Bilateral side rails. 8. Prefers to be in recliner in dayroom. An annual MDS dated 10/4/15, indicated that R29 did not have any pain. The MDS further indicated R29 had no mouth or facial discomfort, no difficulty with chewing, no broken or loosely fitting dentures, and no abnormal mouth tissue. The facility failed to revise R29's care plan to identify the intermittent jaw pain and define subsequent interventions. During observation on 4/6/16, at 9:03 a.m. R29 was holding her left side of jaw with her hand. When asked whether she was having pain R29 responded "It hurts so bad I can hardly talk." When interviewed on 4/6/16, at 9:03 a.m. nursing assistant (NA)-A stated R29 has an upper denture only and R29 had refused oral cares during morning cares. On 4/6/16, at 11:41 NA-B stated she was aware that R29 had jaw pain off and on since January 2016 or possibly longer. R29's care plan, dated 1/12/16, identified R29 had an alteration in comfort related to pain to knees, right shoulder, and back, constipation, gastroesophageal reflux disease (GERD), and osteoarthritis. The care plan further identified R29 having chewing weakness, poor mealtime intake and refusal to eat at times. Intervention identified on care plan included: 1. Monitor for sign and symptoms of pain. 2. Medicate with Tylenol ES [Extra Strength] and Bengay per orders.	F 280		

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F 280	Continued From page 14 3. Apply hot/cold packs to areas of discomfort as resident allows. 4. Small portions regular diet with ground beef and pork roast, pork chops and ham. 5. Staff provide assist as needed at meals. When interviewed on 4/6/15, at 9:55 a.m. registered nurse (RN)-A stated R29 had a history of intermittent jaw pain which had been present for several months. RN-A confirmed the care plan lacked any documentation of jaw pain and there had been no problems, goals and/or interventions established as part of the care plan related to jaw pain. RN-A verified the care plan should have been revised to include this pain.	F 280		
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 ankle and foot support for 1 of 2 residents (R20) reviewed for positioning. Findings include: R20's current diagnoses according to her physicians progress note dated 2/10/16, included dementia, polymyalgia rheumatica, arthritis and	F 309	It is the policy of St. John Lutheran Home to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and social well being in accordance with the comprehensive assessment and plan of care An Occupational Therapy evaluation was completed on resident R20 to assess	5/17/16

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F 309	Continued From page 15 contractures. R20's quarterly Minimum Data Set (MDS) assessment dated 3/6/16, revealed R20 required total assistance of two staff for transfers and did not ambulate. A Care Area Assessment (CAA) did not trigger with the MDS. R20's care plan dated 3/16, indicated R20 was dependent on one to two staff for transfers with a hoyer lift and dependent on staff for repositioning. The care plan also indicated staff assisted her with mobility on and off the unit in a geri-recliner (reclining wheelchair). During observation on 4/4/16, at 3:28 p.m. R20 was observed in the memory care unit seated in a geri recliner in the activity room with legs hanging downward. R20's feet did not reach the floor, were pointed downward and approximately 5 inches from the floor. Further observations of R20 in the dining area at the table were noted at 3:43 p.m., 4:31 p.m., 5:12 p.m. and 6:17 p.m. R20 was seated in a geri recliner with chair in upright position and footrest down, feet were hanging downward without support and did not reach/touch the floor. During observations on 4/5/16, at 1:14 p.m. and 2:03 p.m. R20 was observed to be reclined in the geri recliner in the dining area. R20's footrest remained down and her feet were hanging in a downward position and did not touch the floor. No support was evident. During observation on 4/6/16, at 7:13 a.m. R20 was observed to be sitting upright while fed breakfast by staff. R20's footrest was down with feet hanging in downward position and did not	F 309	proper wheelchair positioning and foot support. The plan of care for resident R20 has been updated for proper wheelchair positioning and foot support. The Facility will update the transfer and mobility assessment form to include chair and wheelchair assessments and will care plan interventions as appropriate for each resident. Audits will be performed by the Director of Nursing or designee weekly for 6 weeks to ensure necessary updates to the residents comprehensive plan of care are being completed. The results of the audits will be reported to the QA & A committee for review and recommendations. Ongoing compliance will be monitored by the Director of Nursing or designee	

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reach the floor. R20's positioning remained the same during observations at 8:13 a.m., 12:27 p.m. and 12:42 p.m. No support was provided for the dangling feet.

It was noted on 4/7/16, at 7:49 p.m. that R20 was seated in a geri recliner while at the dining table. R20's footrest was down with feet hanging in a downward position and did not reach the floor. R20 continued to have feet in downward position, unsupported and approximately 5 inches from the floor.

During an interview on 4/7/16, at 11:44 a.m. registered nurse (RN)-A verified there was no a seating evaluation completed. RN-A indicated that she would not expect R20 to have dangling feet while seated in the geri recliner. On 4/7/16, at 1:35 p.m. RN-A applied gentle range of motion to R20's ankles and after several flexing/pumping motions RN-A was able to get R20's ankles to a 45 degree angle. RN-A verified the ankles seemed stiff.

When interviewed on 4/7/16, at 2:18 p.m. physical therapist (PT)-A indicated that not allowing feet to hang or dangle and resting them on a foot rest for support would be best practice. PT-A indicated feet unsupported could cause contractures (foot drop with feet in fixed downward position). PT-A was not aware of a seating evaluation request/referral for R20.

R20's clinical record lacked evidence of any Occupational Therapy (OT) assessments related to proper wheelchair positioning.

A policy was requested regarding wheelchair positioning, none was provided.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a consistent manner to ensure the safe use of an electric recliner chair for 1 of 3 residents (R29) reviewed for accidents. Findings include: R29 had diagnoses that included dementia with behaviors and Alzheimer's disease. R29's quarterly Minimum Data Set (MDS) assessment dated 1/3/16, identified R29 required extensive assistance of two with bed mobility, transfers, dressing, and toilet use. The MDS further identified R29 with a Brief Interview for Mental Status (BIMS) score of 7/15 indicating severe cognitive impairment. A fall risk assessment dated 4/3/16, identified R29 as high risk for falls related to mental status, being chair bound, inability to walk, antidepressant, diuretic (for edema), and pain medications. On 4/4/16, at 5:18 p.m. it was observed that R29 was sitting in an electric recliner located in the first floor day room. The remote (which controls the up and down motion of recliner) was noted lying on the floor, adjacent to the chair but not within R29's reach.	F 323	It is the policy of St. John Lutheran Home to ensure that the residents environment remains as free of accident hazards as is possible and resident receives adequate supervision and assistance devices to prevent accidents. The care plan for resident R29 has been updated to address safety interventions to include proper use of the electric recliner remote control. Staff were educated on the revised safety intervention to the care plan of resident R29. The facility will assess all current residents and update the care plan as appropriate to include proper use of the electric recliner remote control, including access to the remote control. The facility will update the transfer and mobility assessment form to include use electric recliners and will care plan interventions individualized for each	5/17/16

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F 323	Continued From page 18 On 4/5/16, from 3:11 p.m. to 4:19 p.m. R29 was observed seated in the electric recliner chair located in the first floor dayroom; R29 was in a reclined position and the remote control was tucked behind the chair, not within reach. On 4/6/16, at 9:49 a.m. R29 was again observed to be seated in first floor day room electric recliner chair. The remote control for this chair was not within reach. On 4/7/16 at 9:14 a.m. R29 was observed sitting in the electric recliner chair located in the first floor day room. The remote control for the electric chair was placed next to R29, operational and within reach. On 4/6/16, at 8:25 a.m. nursing assistants (NA)-A and NA-B were interviewed after they had transferred R29 into the electric recliner chair located in the first floor day room. NA-A and NA-B unplugged the remote, and stated the remote was to remain unplugged as R29 would manipulate the chair up and down to the point where she could fall from the electric chair. When interviewed on 4/6/16, at 9:55 a.m. registered nurse (RN)-A stated R29 would "fiddle" with the remote control which operated the electric recliner chair and could potentially fall from this recliner if it was raised too high. RN-A stated she was not sure when staff had initiated removing the remote from R29's access but thought that it was a good plan to prevent R29 from falling from the recliner. When NA-A and RN-B on 4/6/16, at 1:22 p.m. were interviewed, they both indicated it had been three months since the remote was removed from R29's reach because she had been inappropriately controlling the recliner in an up/down motion while seated in this recliner. During interview on 4/7/16, at 9:20 a.m., NA-B and licensed practical nurse (LPN)-A stated that	F 323	resident. Assessments will be done upon admission, quarterly, and/or during a significant change assessment. Chart audits will be conducted by the Director of Nursing or designee of 3 residents weekly for 4 weeks, the 3 residents monthly for 3 months. The results of the audits will be reported to the QA & A committee for review and recommendations. Staff education on the new assessment form will be completed. Ongoing compliance will be monitored by the Director of Nursing or Designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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F 323	Continued From page 19	F 323		

in the past they had observed R29 operate the remote control and lift the recliner to the point where she almost fell from the chair. NA-B further stated she thought R29 had slid out from the recliner before. During review of R29's medical record for the past 12 months there was no evidence in the documentation that R29 had slid from the recliner.

When interviewed on 4/7/16, at 9:14 a.m. NA-C identified she had transferred R29 into the first floor day room recliner with the assistance of NA-A. NA-C stated she was not sure whether the remote control for the chair should be accessible for R29 to operate or not. NA-A stated R29's care plan lacked direction indicating whether the remote control should be accessible or not for R29 to use.

On 4/7/16, at 9:40 a.m. the director of nursing (DON) stated, "They don't know what to do", in reference to the direct care staff and R29's use of the remote to operate the electric recliner chair. The DON verified the active care plan lacked any problems, goals, and/or interventions related to the use of remote control while R29 rests in the electric recliner. The DON verified the care plan should include the use/restriction of the remote to operate the recliner as this could be a safety concern for R29 if used inappropriately.

R29's care plan, dated 1/12/16, identified R29 had a high risk for falls related to dementia with behaviors, poor balance, and need for staff assistance with transfers and ambulation. The care plan further identified R29 having history of restlessness and nervousness. Interventions identified on care plan to reduce fall risk included:

1. Extensive assist of one to two staff for all transfers.

2. Extensive assist of two staff and use of walker with ambulation.

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F 323	Continued From page 20 3. Ambulate with two assist and walker as needed if resident chooses. 4. Prefers to sit in recliner in day room. 5. Defined perimeter mattress on bed and fall mat on floor beside bed. 6. Bilateral side rails 7. Medicate for pain. The facility failed to ensure staff were aware of R29's ability to operate/not operate the electric recliner chair with the use of a remote control. Staff were unsure whether it was safe for R29 to have access to this piece of equipment while seated in the electric recliner to prevent an accident/fall from the chair.	F 323		

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2016**

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ST JOHN LUTHERAN HOME	**201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. John's Lutheran Home was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: The original building was built in 1961 and was determined to be of Type II(000) construction; The 1st Addition was built in 1972 and was determined to be of Type II(000) construction; The 2nd Addition was built in 1987 and was determined to be of Type II(222) construction; The 3rd Addition was built in 1991 and was determined to be of Type II(222) construction, with a portion of the Addition being of Type V(111) construction; The 4th Addition was built in 2000 and was determined to be of Type III(211) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detectors in all Resident	K 000		

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K 000	Continued From page 2 Rooms. The facility has a capacity of 85 beds and had a census of 79 at time of the survey. St Johns Lutheran Home has elected to use the following categorical waivers - Extinguishing Requirements, Capacity of Means of Egress and Combustible decorations on walls, doors and ceilings. Because all of the construction types & heights for an existing health care occupancy met the minimum requirements at NFPA 101 (2000) Table 19.1.6.2, the facility's construction type was downgraded to Type V(111) construction, and surveyed as one building. One Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour between 10:00 AM and 12:30 PM, review of the Battery Emergency Light Testing documentation indicated that the annual 90 minute test on the Battery Wall Mount Emergency Lights was not conducted from April 2015 thru March, 2016. This deficient practice was confirmed with the	K 046	A 90 minute testing of the batter emergency lighting will be completed. A column to document an annual 90 minute testing has been added to the Battery Emergency Light Testing Log. Ongoing compliance will be monitored by the plant operations director	5/13/16

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K 046	Continued From page 3 Building Maintenance Supervisor at the time of discovery.	K 046		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Findings include: During documentatation review between 10:00 AM and 12:30 PM on 04/05/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	A single policy for an "Out of Service" Fire Sprinkler System will be created. Ongoing compliance will be monitored by the plant operations director.	5/13/16
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the	K 155		5/13/16

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K 155	Continued From page 4 shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Findings include: During documentatation review between 10:00 AM and 12:30 PM on 04/05/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155	A single policy for an "Out of Service" Fire Alarm System will be created. Ongoing compliance will be monitored by the plant operations director.	