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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P86V
Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245399**

2. STATE VENDOR OR MEDICAID NO. (L2) **087497000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE FALLS CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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) **01/01/2014**

6. DATE OF SURVEY **2/3/2014** (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) **09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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
	55			
(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 :
Sarah Grebenc, Unit Supervisor 2/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 3/18/2014 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000
03001 Changed ML (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
03/12/2014 (L32)

32. DETERMINATION OF APPROVAL DATE
03/12/2014 (L33)

DETERMINATION APPROVAL

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

Page 2
Provider Number: 24-5399
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective January 17, 2014, the facility is certified for 55 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245399

March 18, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Dear Mr. Allen:

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 January 17, 2014, the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

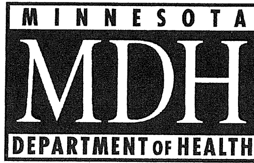
If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 10, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: Project Number S5399024

Dear Mr. Allen:

On January 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 December 18, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 3, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2013, effective January 17, 2014 and therefore remedies outlined in our letter to you dated January 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,

Sarah Grebenc

Sarah Grebenc , Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7365 Fax: 320-223-7348

Enclosure

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

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245399	A. Building B. Wing	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0242 Reg. # 483.15(b) LSC	01/17/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	01/17/2014	ID Prefix F0285 Reg. # 483.20(m), 483.20(e) LSC	01/17/2014
ID Prefix F0323 Reg. # 483.25(h) LSC	01/17/2014	ID Prefix F0356 Reg. # 483.30(e) LSC	01/17/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	01/17/2014
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	01/17/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2/10/14	Signature of Surveyor: 10562	Date: 2/10/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
12/18/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245399	01 - MAIN BUILDING 01	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0051	12/19/2013	ID Prefix Reg. # NFPA 101 LSC K0056	01/16/2014	ID Prefix Reg. # NFPA 101 LSC K0069	01/16/2014
ID Prefix Reg. # NFPA 101 LSC K0147	12/19/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency ✓	Reviewed By	Date:	Signature of Surveyor:	Date:
	BA	2/10/14	10562	2/10/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
12/18/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P86V
Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245399**

2.STATE VENDOR OR MEDICAID NO. (L2) **087497000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE FALLS CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Nicolle Marx, HFE NE II 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/14/2014 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN# 24-5399

The Change of Ownership for Little Falls Care Center is recommended effective January 1, 2014. Legal entity of the seller was Lutheran Care Center, Inc. - legal entity of the buyer is Little Falls Health Services. Refer to the attached documents: CMS-671; CMS-1561 Health Insurance Benefit Agreement; HHS-690 Assurance of Compliance; CMS-855; Approval letter from National Government Services dated January 10, 2014; Office of Civil Rights materials and documentation that substantiates the change of ownership. Facility also had a name change. New name is Little Falls Care Center and the previous name was Lutheran Care Center.

At the time of the standard survey completed December 18, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7369

January 3, 2014

Mr. Scot Allen, Administrator
Lutheran Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

RE: Project Number S5399024

Dear Mr. Allen:

On December 18, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

<u>Informal Dispute Resolution</u> - 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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

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 January 27, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 27, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 18, 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 June 18, 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, 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

RECEIVED JAN 17 2014 MN Dept of Health St.Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ____ B. WING ____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that each resident's preference for getting up in the morning was respected for 1 of 3 residents (R48) who was reviewed for choices. Findings include: R48's admission Minimum Data Set (MDS) dated 4/29/13, indicated R48 was cognitively intact. R48 was interviewed in her room on 12/16/13, at	F 242	**F 242 SELF-DETERMINATION** The facility recognizes and supports each resident's right to Self-Determination and does allow all residents to make choices. *Identified Resident:* Staff were immediately reeducated on this resident's right to choose and be allowed to make choices regarding schedule and activities. RNs promptly updated any staff direction to reflect this resident's right to Self-Determination. *Other Potential Residents:* All other residents were reviewed and staff direction has been assessed to assure each resident's right to Self-Determination is not restricted.	OK 2/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/16/14

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
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 242	Continued From page 1 5:12 p.m. R48 stated, "They set the time when you get up here. I don't eat breakfast. I like to sleep in. They wake me up at 9:30 or 10:00...I'd like to sleep until 11...I've told them...they say no." On 12/17/13, at 1:30 p.m., a second interview was completed with R48. R48 stated that she has been told by the staff that she has to get up at 9:30 a.m. or she has to wait until after lunch to get up, but then she misses lunch. R48 also stated, "My body hurts. I need to sleep in." During an interview on 12/17/13, at 3:35 p.m., director of social services (DSS) stated as far as she knew, R48 was able to get up in the morning when she wanted. DSS stated she had talked to R48 many times about her preferences. During this interview, registered nurse (RN)-B interrupted and said, "No, we just recently changed that. She has to be up by 9:30 so that we can do cares for other residents and get them to lunch." RN-B went to file cabinet and pulled out the "group sheet" that nursing assistants use to direct cares for residents. RN-B pointed to R48's information, which included in bold print,"Assist with morning cares at 9:30, resident is to get up at this time." DSS indicated she was not aware of that change and they, "Would have to talk about that." DSS verified that residents' preferences should be respected. During an interview on 12/18/13, at 7:45 a.m., nursing assistant (NA)-C stated, according to the group sheet [R48] "Needs to be up at 9:30. I'll probably go in closer to 10. Yesterday I went in at 10 to 10 and she said, 'It's not 10 yet.' She likes to sleep in." When asked if R48 gets upset when she's gotten up early, NA-C stated, "Yes."	F 242	F 242 Continued: *Systematic Changes:* Residents have been and will continue to review their rights at monthly Resident Council Meetings. The facility has taken this opportunity to remind staff of each resident's right to Self-Determination at a January 14, 2014 Staff Meeting. *Auditing/Monitoring:* Resident Council attendees will be asked each month for the next 3 month about their ability to make personal choices. Director of Social Services will monitor to assure compliance and will randomly audit 4 residents each week for 8 weeks to assure residents are allowed their right of make choices. The Director of Social Services or designee will report to facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 242	Continued From page 2 During an interview on 12/18/13, at 11:39 a.m., RN-A stated she was not aware that R48 was being told that she needed to be up by 9:30. As far as she knew, R48 usually slept until 10 or so. RN-A stated R48 wanted to sleep until noon, "But all of the nursing assistants are assisting in the dining room at that time and there is no one to get her up. "[R48], Is given the choice to wait until after lunch to get up." During an interview on 12/18/13, at 12:55 p.m., director of nursing (DON) stated "[R48], Can sleep until she wants to get up." When shown the group sheet that indicated R48 was to get up at 9:30, DON stated she wasn't aware that statement was on there. DON verified that R48 should be able to chose what time she gets up. DON also stated, "There is always someone available to get her up, even during lunch...staff can always call someone for help if needed." A review of the facility's policy titled, Your Rights Under the Combined Federal and Minnesota Residents Bill of Rights, undated, included "You have the right to choose activities, schedules, and health care...and make choices about aspects of your life in the facility that is significant to you."	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	**F279 COMP. CARE PLANS** Facility does use assessment results to develop, review and revise resident's comprehensive plan of care. *Identified Resident:* The care plans for R15 and R 21 were immediately updated by the RN Case Managers, care plans will be reviewed and updated each quarter or if changed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ____ B. WING ____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(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 279	Continued From page 3 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan to address an indwelling Foley catheter use for 2 of 3 residents (R15, R21) reviewed with urinary catheters. Findings include: R15's care plan did not identify the use of an indwelling Foley catheter nor interventions related to providing cares. During interview on 12/16/13, at 2:47 p.m., registered nurse (RN)-A identified R15 had a Foley catheter. The minimum data set (MDS), care area assessment (CAA), dated 11/5/13, identified the use of an indwelling catheter for R15 related to terminal illness status. The CAA further identified the catheter status would be addressed on the care plan with the overall objectives to avoid complications and symptom relief or palliative measures. A progress note dated 11/14/13, identified hospice had been in to see R15 and a catheter	F 279	F 279 Continued: *Other Potential Residents:* All other residents with catheters were reviewed to assure their care plan addressed catheter information. *Systematic Changes:* Appropriate staff were reminded to develop a comprehensive care plan for each resident's need identified through a comprehensive assessment. *Auditing/Monitoring:* The Director of Nursing will review 4 care plans each week for 8 weeks to assure an accurate and timely comprehensive care plan is developed for each resident. Director of Nursing or designee will report to facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ____ B. WING ____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 279	Continued From page 4	F 279	This Page Intentionally Blank	

had been placed to straight drainage.

During an interview on 12/17/13, at 3:22 p.m., RN-A reviewed R15's care plan and confirmed there was a lack of information related to the catheter. RN-A indicated catheter information should have been included on the care plan. RN-A stated the hospice staff had inserted the Foley catheter and had access to the facilities electronic medical records, so they should have updated the care plan.

R21's care plan did not identify the use of an indwelling Foley catheter nor interventions related to providing cares.
During an interview on 12/16/13, at 2:52 p.m., RN-A identified R21 had an indwelling Foley catheter which had been in use for nearly a year. The MDS, CAA dated 12/6/13, identified the use of an indwelling catheter for R21 related to terminal illness status. The CAA further identified the catheter status would be addressed on the care plan with the overall objective of avoiding complications.
During an interview on 12/17/13, at 3:22 p.m., RN-A reviewed R21's care plan and confirmed there was a lack of information related to the catheter.

During an interview on 12/18/13, at 10:00 a.m., licensed practical nurse (LPN)-A stated she would expect to find information on how to care for a catheter such as when to change it or if there were any special concerns regarding precautions on a residents care plan.

During an interview on 12/18/13, at 10:43 a.m., hospice RN-A stated she had access to the facility's electronic medical records, but had read

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 279	Continued From page 5 only access. Hospice RN-A indicated she could go in a read a medical record, but was unable to complete any documentation in the electronic medical record. During an interview on 12/18/13, at 11:19 a.m., director of nursing (DON) stated her expectation was that if a resident had an indwelling Foley catheter, it would be noted on the care plan along with interventions related to it use. DON stated R21 had been admitted to the facility with the Foley catheter and there had been a turnover in staff at the same time, so updating the care plan must have been missed. DON further stated R15's care plan should have been updated by facility staff when the Foley catheter was inserted and was also missed. Review of the facility's policy, Guide For Nursing Care Plan, dated 05/04 revealed personalized plans of daily care would be developed with resident's needs so all nursing staff could read and follow care guidelines for continuity of care.	F 279		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;	F 285	**F 285 PASRR REQUIREMENTS** Facility does coordinate PASRR assessments for each appropriate resident. *Identified Resident:* R 48 was admitted at the request of the local mental health rehabilitative authority (County). The Level I screening was completed. The Level II was the County's responsibility. The facility reminded the County to complete the screening on 12/17 and that screening was done by 12/19. The facility did not fully monitor the Level II screening's completion & timeliness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(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 285	Continued From page 6 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the comprehensive Level II preadmission screening and psychosocial and/or rehabilitative assessment as required to determine mental health rehabilitative services needed, for 1 of 1 residents (R48) reviewed for Preadmission Screening and Resident Review (PASRR) Level II screening.	F 285	F 285 Continued: *Other Potential Residents:* The facility has reviewed all residents to verify there are no other resident requiring PASRR screenings. *Systematic Changes:* Staff will assure any residents who required PASRR screening will receive those screenings. *Auditing/Monitoring:* Director of Social Services will audit to assure PASRR are completed accurately and timely, and verify weekly for 8 weeks. The Director of Social Services or designee will report to facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ____ B. WING ____	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 285	Continued From page 7 Findings include: R48 was identified by the facility as having a Level II PASRR screening. The facility also identified R48 as DD (developmental disability). The Level I Screening for Mental Retardation and Mental Illness form, completed 5/22/13, indicated the form was to be completed for any admission to a medical assistance certified nursing facility. The Level I screening form identified R48 had been considered to have mental retardation or a related condition in the past. Due to this finding, the Level I screening form indicated R48 needed to be referred to the county offices for persons with developmental disabilities or related conditions for evaluation and determination of need for specialized services. During an interview on 12/18/13, at 10:30 a.m., director of social services (DSS) stated she did not have a copy of the Level II PASRR screening for R48. DSS indicated she had placed a call to the county worker and was waiting for a response. Review of the facility's PASRR policy, dated 5/04, revealed, "The Level II process includes the determination of need for further evaluation...The purpose of the diagnostic assessment is to confirm the diagnosis and determine if specialized services are needed or, if not, which routine mental health services would be beneficial."	F 285	This Page Intentionally Blank	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 323	Continued From page 8 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 ensure grab bar equipment was maintained in a safe and functional manner for 1 of 4 (R42) residents reviewed for accidents and the facility did not assess R42's grab bars for safety prior to use. Finding include: R42's quarterly minimum data set (MDS), dated 10/10/13, included diagnoses of morbid obesity and arthritis and identified extensive assistance of one staff for bed mobility. R42's care plan, dated 10/09/13, did not identify the use of the grab bars for turning or repositioning in bed. On 12/16/2013, at 2:22 p.m., R42's bed was observed with grab bars on both sides of the bed. The right grab bar was intact. The left grab bar was observed to be loose and unbolted where the lower portion attached to the bed frame, making it unstable for weight bearing. R42 described using the grab bars for bed mobility, however it was difficult to change position due to only one of them being functional. R42 commented the grab bar had been in disrepair for, "A couple of	F 323	**F323 FREE OF ACCIDENT HAZARDS – SUPERVISION - DEVICES** Facility does ensure each resident's environment remains as free of accident hazards as possible and assesses and provides each resident with supervision and assistance devices to prevent accidents. *Specific Resident:* This resident's grab bars had been promptly repaired after each repeated breakage. The equipment was again repaired on 12/17/13. The resident had been assessed for the need of grab bar usage and proper equipment was identified. On 12/17/13 the RN Case Manager reassessed and documented the functional value of this resident's grab bar usage. *Other Potential Residents:* RN Case Manages have reviewed all residents to verify grab bar usage has been properly assessed. *Systematic Changes:* RN Managers have been reminded of facility policy regarding proper assessment of residents benefiting from grab bar usage. Environmental Services will use the work order system to coordinate repairs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 323	Continued From page 9 months" and that it had previously been reported it to maintenance. On 12/16/13, at 2:41 p.m. in R42's room, the environmental service director (ES)-D verified the grab bar needed repair. He further stated the normal facility procedure was for staff to fill out a maintenance slip for broken equipment. On 12/17/13, at 9:17 a.m., R42's the grab bar had not been repaired. On 12/18/13, at 7:09 a.m., R42's grab bar was still not repaired. Nursing assistant (NA)-A verified that the grab bar had been broken, "At least a couple of months." NA-A stated R42, "Rolled better to the left" in bed, and the grab bar would be helpful for her bed mobility. NA-A was unaware if there was a work order filled out for the broken grab bar. During interview about the status of R42's grab bar repair on 12/18/13, at 7:45 a.m., ES-D stated he would fix it after 11:00 a.m. today when R42 got up. During interview on 12/17/13, at 3:02 p.m., registered nurse (RN)-A said half rails and grab bars were assessed via the safety assessment which should be in the electronic chart if the resident is using grab bars. R42's most recent equipment safety assessment, dated 10/9/13, revealed no mobility aids in use and no use of siderails or half rails. During an interview on 12/18/13, at 11:16 a.m., the director of nursing (DON) stated her expectation would be for a safety assessment to	F 323	F 323 Continued: *Auditing/Monitoring:* RN Case Managers will audit R 42's grab bars weekly for 4 weeks to assure the equipment is in proper working conditions. Director of Nursing will audit 4 residents each week for 8 weeks regarding assessments for positioning devices. Director of Nursing or designee will report to facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 323	Continued From page 10 be done before grab bars were used and these were usually completed by the RN case manager. The policy provided by the facility, entitled Restraints--Physical, dated 5/04, lacked guidance on assessment of grab bars.	F 323		
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. 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.	F 356	**F356 NURSE STAFFING INFO** Facility does post direct nursing care staffing information on a daily basis. _Specific Situation:_ The facility updated its format and process to daily identify the number of employees and hours of actual work by shift and have trained appropriate personnel. _Other Potential Situation:_ No other potential situations. _Systematic Changes:_ Addressed by the specified action. _Auditing/Monitoring:_ Administrator will review the Nurse Staffing Information Form 4 times each month for 8 weeks to assure proper form completion. Administrator or designee will report to the facility's Quality Assurance Committee (QA) for review and input. _Completion Date:_ January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the actual hours worked for nursing facility staff were posted. This had the potential to affect all 48 residents in the facility and visitors. Findings include: On 12/16/13, at 12:20 p.m., the facility's daily nursing hours posting, entitled Nursing Staff Report, for the dates of 12/8/13 through 12/16/13 was observed in a three-ring binder in front of the reception desk. The form listed the daily census, class of nursing personnel and total hours per day for morning shift, afternoon shift and night shift. The times of the shifts were not identified on the form, nor were any short shifts listed. During interview on 12/18/13, at 9:20 a.m., the nursing scheduler (NS)-B, stated she updates the total nursing hours daily and the facility utilizes short shifts every day on both day and evening shifts. During interview on 12/18/13, at 11:16 a.m., the director of nursing (DON) verified the procedure for the posting of nurse staffing hours was to update the total nursing hours per shift and display them in the three-ring binder at the reception desk. She confirmed the use of short shifts during the day and evening. During interview on 12/18/13, at 11:40 p.m., the DON stated they did not have a policy regarding the posting of staffing hours.	F 356	This Page Intentionally Blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the large can opener in the kitchen was maintained, and the dishes and utensils were stored in a sanitary manner. This had the potential to affect all 48 residents in the facility that eat meals served from the kitchen. Findings include: On 12/16/13, at 12:10 p.m., during the initial kitchen tour with the dietary director, the steam table which had storage below it for large cooking pots and pans was observed to have food debris and grease splatters. When the large pots were moved, grease rings were observed from the top of the pot. Also during the tour, drawers where food utensils were stored were observed to have dried on food splatters and spills down the outside of the drawers. Finally, the large can opener was observed to have black debris built-up around the top of the blade, the blade had a gauge missing out of the side of it and metal shavings were missing on the blade. These	F 371	**F371 SAFE FOOD HANDLING** The facility does handle and store food under sanitary conditions. _Specific Situation:_ The facility has updated its Dietary Cleaning Policy, reviewed individual shift cleaning schedules and clarified its dietary supplement policy. The new can opener, which the facility had ordered, arrived and has been installed. _Other Potential Situation:_ No other potential situations. _Systematic Changes:_ Staff have been trained regarding the policy updates. _Auditing/Monitoring:_ Dietary Director will audit both the cleaning process and the dietary supplement marking process 4 times each month for 2 months to assure proper completion. Dietary Director or designee will report to facility's Quality Assurance Committee (QA) for review and input. _Completion Date:_ January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(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 371	Continued From page 13 observations were verified by the dietary director. On 12/18/13, at 7:15 a.m., a revisit to the kitchen revealed the storage of the pots and pans had been cleaned however the drawers where utensils were stored, continued to have the dried food spills and splatters on the outside. This observation was again verified by the dietary director. The cleaning schedule indicated the steamtable should be cleaned daily as well the can opener. The storage drawers should be cleaned monthly. Review of the, Cleaning Schedule policy, undated, revealed each department had cleaning duties defined on a schedule (i.e. monthly, weekly and daily duties). The dietary manager would post the monthly schedule. Upon completion of task, each employee would initial on the date to verify completion. The cleaning would be monitored by the dietary manager for completion.	F 371	This Page Intentionally Blank	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 431	Continued From page 14 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper labeling and storage of medications in two of two medication rooms and did not ensure expired medications were dated when opened for 2 residents (R2 and R19). Findings include: During an observation of the medication room for units 100 and 200 on 12/17/13, at 10:50 a.m., the refrigerator had seven small (6 ounce) Mighty Shakes (nutritional supplement) closed and undated, two large Mighty Shakes (32 ounces) closed and undated, and one large Mighty Shake opened and undated. It also contained seven	F 431	**F431 DRUG LABELING** Drugs and biologicals in the facility are properly labeled and stored in accordance with professional practices. *Specific Situation:* Nursing staff immediately requested new & unopened Mighty Shakes and Magic Cups from supply and dated those items before placing in use. Expired insulin vials and pens were properly destroyed and new ones immediately placed into use. *Other Potential Residents:* All Mighty Shakes, Magic Cups and insulin supplies were reviewed to assure proper dating. *Systematic Changes:* Appropriate staff were retrained in regards to proper dating. *Auditing/Monitoring:* RN Case Managers will audit drugs and biological for proper dating 4 times per week for 8 weeks. Director of Nursing or designee will report to facility's Quality Assurance Committee (QA) for review and input. *Completion Date:* January 17, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 431	Continued From page 15 Magic Cups (nutritional supplement) closed and undated. When interviewed at the time of the observation, registered nurse (RN)-A indicated the shakes should be dated when opened. During an observation of the medication room for units 300 and 400 on 12/17/13, at 10:55 a.m., the refrigerator had one large Mighty Shake open and undated, three large Mighty Shakes closed and undated, and seven small Mighty Shakes closed and undated. When interviewed at the time of the observation, RN-B indicated these items were not required to be dated. The manufacturer recommendations noted the Mighty Shake to have a shelf life of 14 days when refrigerated and thawed, and the Magic Cup to have a shelf life of 5 days when refrigerated and thawed. During an observation of the medication cart for units 100 and 200 on 12/17/13, at 11:05 a.m., with licensed practical nurse (LPN)-B the following were noted. A Levemir (insulin) pen for R2, was opened and undated, and two Novolog (insulin) vials for R2, one dated as opened 11/14/13 (expired) and one dated as opened 10/23/13 (expired). Also, one Humulin 70/30 pen (insulin) was opened and undated for R19. When interviewed during the observation, LPN-B indicated she would date the Levemir pen for R2 from two days prior, after stating it appeared it had been used a couple times. She was asked to call the RN prior to doing this. RN-B came to the medication cart at 11:10 a.m. and she noted the insulin was to be dated when opened and it was not acceptable to date it at this time. Review of the facility's policy titled Storage of	F 431	This Page Intentionally Blank	

PRINTED: 01/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 431	Continued From page 16 Drugs identified, "Drugs required to be stored under refrigeration will be stored at the appropriate temperatures. All drugs moved to or from refrigeration upon opening shall be marked with the date upon opening." It also identified, "Drugs shall not be kept on hand after the expiration date (make sure to check the label and the actual container for the drug extirpation [sic] date.) No contamination or deteriorated drugs shall be available." Review of the facility's policy titled NDS Supply to Nursing Dept. (undated) revealed, "1. Nursing department will request supply of product needed from the freezer in dietary department. 2. Nursing department adds date to product when transferred to put in refrigerator. Product is to be used within 10 days from transfer from freezer to refrigerator. 3. As product is opened and used, if there is a partial container, it is labeled with the date of opening."	F 431	This Page Intentionally Blank	

LUTHERAN CARE CENTER

1200 NE 1st Avenue
Little Falls, MN 56345 Phone # 1-320-632-9211 Fax # 1-320-632-2097

Lutheran Care Center – Survey Exit – December 18, 2013
Survey Addendum

Additional and Clarification of Information:

F 242 - SELF DETERMINATION:

Residents are asked on admission and at each care conference regarding their preferences, particularly arising and retiring times. Those preferences are transferred to the resident's care plan and their staff assignment group sheets.

The RN Case Manages re-asked each resident at the time of the survey what their preferences were, particularly arising and retiring times. The RN Case Managers checked to be sure the resident's preferences were correctly documented in the care plans and staff assignment group sheets.

Staff were educated at the Nursing Meeting on 01/14/14 and reminded to inquire of each resident regarding their preference before performing a service.

F 279 – COMPREHENSIVE CARE PLANS:

The Director of Nursing talked with each hospice director and their RN Case Managers about communication and ensuring their interventions are properly care planned. Hospice has access to the electronic care plan and are able to provide input and updates as necessary. The facility's RN Case Managers interact with hospice staff on almost a daily basis and use that interaction to identify new interventions.

F 323 – FREE OF ACCIDENTS:

Staff were reeducated on the process of work order completion at the time of survey and again at the Nursing Meeting on 01/14/14.

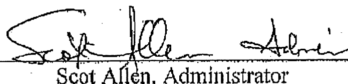
F 371 – SAFE FOOD HANDLING:

The Dietary Director is including the can opener in the auditing process.

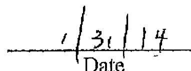
The Dietary Director is weekly auditing the supplement marking system to address dates when the product is taken from the freezer, delivered to the floor, put into use and the proper expiration date.

F 431 – DRUG LABELING:

The Dietary Director updated the Supplement Policy to reflect the updated expiration dates and is auditing to assure those dates are appropriately met and product disposed of before the expiration date.



Scot Allen, Administrator



Date

"WHERE FRIENDS ARE LIKE FAMILY"

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

F5399022

PRINTED: 01/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Lutheran Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. POC ok FS 1-24-13 RECEIVED JAN 22 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 12/18/13 DC: 1-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scot Allen TITLE: Administrator (X6) DATE: 1/16/14

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
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lutheran Care Center is a 1 story building with no basement. It was constructed at four different times. The original building was built in the 1964 and was determined to be of a Type II(222) construction. In 1975 an addition was added to the east of 200 Wing that was determined to be Type II (222) construction. In 1992 an addition was added to the west of 100 Wing that was determined to be Type II (000) construction. In 2001 an addition was added to the southwest that was determined to be Type II(000). The facility is fully protected by a fire sprinkler system. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces which is monitored for automatic fire department notification. Because the original building and the 3 additions are of the same type of construction type allowed for existing buildings, the facility was surveyed as one building.	K 000	This Page Intentionally Blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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	Continued From page 2 The facility has a capacity of 55 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**K 51 WARNING SYSTEM** The facility does have an effective fire warning system.	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain unobstructed access to 1 of several manually actuated alarm-initiating	K 051	*Corrective Action(s):* Access to the noted pull station was immediately cleared and unobstructed access assured. *Monitoring:* Environmental Services Director coordinated the correction and will monitor to assure compliance *Completion Date:* ~~December 18, 2013~~ 12-19-13 TB	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 051	Continued From page 3 devices located throughout the facility in accordance with NFPA 101 Life Safety Code (00), Sections 19.3.4.2 and 9.6.2.6 as well as NFPA 72 National Fire Alarm Code (99), Sections 2-8.2.1. This deficient practice could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 12/18/2013, during the facility walk through it was observed that the manual fire alarm box located next to the boiler room's exit doors had boxes and other equipment that was obstructing access to that device in the event of an emergency. The requirements of both the NFPA 101 (00) and the NFPA 72 (99) require that manual fire alarm boxes shall be unobstructed and accessible at all times. This deficient practice was verified by the Environmental Services Manager (BP).	K 051	This Page Intentionally Blank	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 056	Continued From page 4 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 101 Life Safety Code (00) section 9.7.2.1, NFPA 72 National Fire Alarm Code (99) section 3.8.3.2.5.1, and NFPA 13 the Standard for the Installation of Sprinkler Systems (99) sections 5-3.1.5.2, 5-6.3.4, and 6-1.1.5. The failure to maintain the sprinkler system in compliance with all applicable codes could allow the fire suppression system being placed out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 12/18/2013, observations and documentation review has reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. That there was speaker wires and speaker attached to the and hung from the fire sprinkler piping located in the boiler room, 2. The facility could only provide documentation verifying that 1 of 3 deficiencies that were noted	K 056	This Page Intentionally Blank	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(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 056	Continued From page 5 on the Annual Fire Sprinkler inspection report were corrected and brought into compliance 3. Inside of the maintenance supervisors office there are two different types of sprinkler heads, one is a glass bulb quick response sprinkler head and the other is a soldered link standard response sprinkler head. These dissimilar types of sprinkler heads are located in the same room/compartment. 4. There are 4 sprinkler heads that are part of an abandoned domestic water line sprinkler system that was left in place. One of the four sprinkler heads that is on the domestic sprinkler system is located within 4 feet of a sprinkler head that is connected to the facility's automatic fire sprinkler system that is tied in the fire alarm system. The activation of the domestic head could cause the cold soldering of the sprinkler head that is part of the facility's automatic fire sprinkler system causing a lack of adequate fire suppression coverage and would delay the fire alarm activation and notification for the facility in the event of a fire. This deficient practice was verified by the Environmental Services Manager (BP).	K 056	**K 56 SPRINKLER INSTALLATION** The facility does have a sprinkler system which was correctly installed. *Corrective Actions:* 1. Noted sprinkler piping was immediately cleared. 2. Annual Inspection items have been corrected. 3. Similar sprinkler heads have been installed in the noted area. 4. Sprinkler heads noted to be on a domestic water supply have been removed and adequate suppression coverage assured. *Monitoring:* Environmental Services Director coordinated the correction and will monitor to assure compliance. *Completion Date:* January 16, 2014	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069	**K 69 ACCESSIBLE PULL BOX** *Corrective Actions:* Equipment hindering access to the pull station has been moved. *Monitoring:* Environmental Services Director coordinated the correction and will monitor to assure compliance. *Completion Date:* January 16, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 069	Continued From page 6 Based on observations, it was determined that the facility has failed to ensure the accessibility to the manual activation pull station for the hood suppression system is in compliance with the requirements of NFPA 96 Fire Extinguishing systems (98) section 7-5.1. This deficient practice could affect 10 of 55 residents, staff and visitors. Findings Include: On facility tour between 9:30 AM to 3:30 PM on 12/18/2013, observations revealed that the manual activation pull station was block by a cart that had a soft drink dispenser and a cash register on it that was obstructing the accessibility of the manual pull station in the event of an emergency. This deficient practice was verified by the Environmental Services Manager (BP).	K 069		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was using extension cords in place of permanent wiring that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 10 of 55 residents, staff and visitors.	K 147	**K 147 EXTENSION CORDS** *Corrective Actions:* Extension cords were immediately removed for safety. *Monitoring:* Environmental Services Director coordinated the correction and will monitor to assure compliance. *Completion Date:* ~~December 18, 2013~~ 12-19-13 TP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/18/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

(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 147	Continued From page 7 Findings include: On facility tour between 9:30 AM to 3:30 PM on 12/18/2013, observations revealed that the facility failed to limit the use of extension cords within the facility as seen by the the extension cords used to power the Christmas tree located at the main entry receptionist desk, the Internet router located at the north nurses station and one that was located in resident room 211. This deficient practice was verified by the Environmental Services Manager (BP).	K 147	This Page Intentionally Blank	