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:	PAQX	
Faci	lity ID: 00116	

		10 22 00	CETED DI		E SCILLET TIGET		ruemey ib. corre
MEDICARE/MEDICAID PROVI	DER	3. NAME AND AI			.veep.p.	4. TYPE OF ACTI	ON: <u>7</u> (L8)
NO.(L1) 245372		(L3) ST LUKES 1 (L4) 1219 SOUT		CARE CE	NTER	1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAL	D NO.	(L5) BLUE EAR			(L6) 56013	3. Termination 5. Validation	4. CHOW 6. Complaint
(L2) 428540900	CONVENCION			20011	. ,	7. On-Site Visit	9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Aft	er Complaint
	/ 10/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC	<u> </u>	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Other		10 THE EACH ITS	/ IC CEPTIFIED	4.0			
11LTC PERIOD OF CERTIFICATION From (a):)N	10.THE FACILITY A. In Complia		AS:	And/Or Approved Waivers Of	The Following Peguirer	nente:
To (b):			equirements		Technical Personnel		
(0).			e Based On:		3. 24 Hour RN	7. Medical D	
		1. A	cceptable POC		4. 7-Day RN (Rural SI		
12.Total Facility Beds	89 (L18)				5. Life Safety Code	9. Beds/Roor	n
13.Total Certified Beds	89 (L17)	Requirements	and/or Applied	Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN	1			15. FACILITY MEETS	(===)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
89					(+) (-) () (-).		
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MADVS (IE ADDI IC)	ADLE SHOWLTC CA	ANCELLATION	DATE).			
10. STATE SURVET AGENCT REI	WARKS (II AI I LICA	ABLE SHOW LIC CA	ANCELLATION	DAIL).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Kathryn Serie, Unit S	upervisor	0	05/08/2017		Kamala Fiske-Downing,	Enforcement Spec	cialist 05/08/2017
	DE II EO DE	COMPLETED I	DV HOEA DI	(L19)	OFFICE OF CIVICIES	NEARE A CENCY	(L20)
PA	KI II - IO BE				L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Fina Ownership/Contr 	ancial Solvency (HCFA-25 rol Interest Disclosure Stm	
1. Facility is Eligible to	Participate				3. Both of the Abov		
2. Facility is not Eligib	le (L21)						
				1			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	[:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00		
12/01/1986					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension	n of Admissions:	(T.44)		04-Other Reason for Withdrawar	07-Provi	der Status Change
(L27)	B Rescind S	uspension Date:	(L44)			00-Activ	e
	B. Resema S	aspension Bute.	(L45)				
28. TERMINATION DATE:	29	O. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION	I OF APPROVAI	DATE			
1 01 0110 100	(L32)			(L33)	DETERMINATION APP	DOWAI	
	(152)			(133)	DETERMINATION APP	KO VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245372

May 8, 2017

Ms. Margaret Brandt, Administrator St. Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

Dear Ms. Brandt:

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 20, 2017 the above facility is certified for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 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 questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 8, 2017

Ms. Margaret Brandt, Administrator St Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

RE: Project Number S5372026

Dear Ms. Brandt:

On January 30, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 13, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 10, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 16, 2017 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 January 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 13, 2017, effective January 20, 2017 and therefore remedies outlined in our letter to you dated January 30, 2017, 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.

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

DOCT CEDTIEICATION DEVICIT DEDODT

	PU51-C	EKIIFICAII	DIN KENISH I	TEPORI		
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CON A. Building	STRUCTION			DATE OF REVI	ISIT
245372 _{Y1}	B. Wing			Y2	3/10/2017	Y3
NAME OF FACILITY			STREET ADDRESS, 0	CITY, STATE, ZIP CODE		
ST LUKES LUTHERAN CARE	CENTER		1219 SOUTH RAMSE	Υ		
			BLUE EARTH, MN 56	013		
This report is completed by a corrected and the date such corrected number and the ider the survey report form).	encies previously orrective action v	reported on the CMS-2 vas accomplished. Eac	2567, Statement of Defice the deficiency should be for	siencies and Plan of Correc ully identified using either t	tion, that have b he regulation or	LSC
ITEM	DATE	ITEM	DATE	ITEM	DATE	-

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix F0309	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # 483.24, 483.25	(k)(l) Completed	Reg. #	483.90(i)(5)	Completed	Reg. #		Completed
LSC	01/20/2017	LSC		01/20/2017	LSC		-
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		- -
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		- -
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		_
REVIEWED BY STATE AGENCY	REVIEWED BY	DATE	SIGNATUR	E OF SURVEYOR		DATE	
	(INITIALS) KS/kfd	5/8/2017			03048		10/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVE	Y COMPLETED ON			DRRECTED DEFICIENT IENCIES (CMS-2567)		U IT\(0	s 🗆 no
Form CMS - 2567B (09/9	2) EF (11/06)		Page 1 of 1		EVENT	ΓID: PAQX1	2

POST-CERTIFICATION REVISIT REPORT

	PU31-C	ENTIFICAL	ION REVISIT F	TEPONI	_
PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER	•	ISTRUCTION · MAIN BUILDING 01			DATE OF REVISIT
245372	Y1 B. Wing			Y2	2/16/2017 _{Y3}
NAME OF FACILITY			STREET ADDRESS, (CITY, STATE, ZIP CODE	
ST LUKES LUTHERAN CA	RE CENTER		1219 SOUTH RAMSE	Υ	
			BLUE EARTH, MN 56	013	
This report is completed by program, to show those def corrected and the date such provision number and the ic the survey report form).	ciencies previously corrective action v	reported on the CMS was accomplished. Ea	s-2567, Statement of Deficach deficiency should be for	iencies and Plan of Correctully identified using either the	tion, that have been ne regulation or LSC
ITEM	DATE	ITFM	DATE	ITEM	DATE

Y4			Y5	Y4	ı		Y5	Y4			Y5
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0293		01/18/2017	LSC	K0351		01/18/2017	LSC	K0363		01/17/2017
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #			Completed	Reg. #			Completed
LSC	K0372		01/13/2017	LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			-	LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			-	LSC				LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			-	LSC				LSC			
REVIEWI STATE A		REVIEW (INITIAL	-S)	DATE 5/8/201	17	SIGNATURE OF	SURVEYOR	35482		DATE	6/2017
REVIEWI CMS RO	ED BY	REVIEV (INITIAL		DATE	1 /	TITLE		JJ+02		DATE	012011
FOLLOWUP TO SURVEY COMPLETED ON 1/11/2017			ETED ON	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

ID: PAQX

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility ID: 00116
MEDICARE/MEDICAID PROVIDER		3. NAME AND AI			· · · · · · · · · · · · · · · · · · ·		4. TYPE OF A	ACTION: 2 (L8)
NO.(L1) 245372		(L3) ST LUKES		CARE CE	NTER		1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAID NO.		(L4) 1219 SOUTI			(L6) 5 0	(012	3. Terminatio	
(L2) 428540900		(L5) BLUE EAR	I'H, MN		(L6) 30	5015	5. Validation 7. On-Site Vis	6. Complaint sit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SU			<u>02</u> (L7)		8. Full Surve	y After Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA		, <u>r</u>
6. DATE OF SURVEY 01/13/2 8. ACCREDITATION STATUS:	2017 ^(L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Rav	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEAR	ENDING DATE: (L35)
ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPICE		09/30	
2 AOA 3 Other		V15.11	00 01 1/01					
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		A. In Complia	ince With		And/Or Approve	d Waivers Of	The Following Requ	
To (b):			equirements e Based On:		2. Techni	ical Personnel	6. Scope	e of Services Limit
		•			3. 24 Hot			cal Director
12.Total Facility Beds	89 (L18)	1. A	cceptable POC			RN (Rural SN	_	t Room Size
13.Total Certified Beds	89 (L17)	X B. Not in Con	npliance with Prog	gram	5. Life Sa	afety Code	9. Beds/	Room
			and/or Applied V	-	* Code: B	*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MI	EETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L15)	
89								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
45. GURLEVOR GIGULEURE					40. GEVEE GVEE	EVI L GENIGI	, ppp of the	
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL	Date:
Susan Kalis, HFE NE II		0	2/09/2017	(L19)	Kamala Fiske-	-Downing, I	Enforcement S	<u>Specialist</u> 03/13/2017 (L20
PART I	I - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR	SINGLE S	TATE AGENC	Y
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	H CIVIL			ncial Solvency (HCF	
1. Facility is Eligible to Partici	pate	RIGI	HTS ACT:			nership/Contro		e Stmt (HCFA-1513)
2. Facility is not Eligible					J. Do.	in of the Above	·	
	(L21)							
22. ORIGINAL DATE 23	. LTC AGREE!	MENT 24	4. LTC AGREEN	MENT	26. TERMINATI	ON ACTION:		(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY	_00	INV	OLUNTARY
12/01/1986					01-Merger, Closur	e	05-F	ail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	W/ Reimburse	ement 06-F	ail to Meet Agreement
	. ,	VE SANCTIONS	(==+)		03-Risk of Involunt	tary Termination	n <u>OTH</u>	IER
27.		n of Admissions:			04-Other Reason fo	or Withdrawal		rovider Status Change
	-		(L44)				00-A	Active
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	O. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
((L28)			(L31)				
21. BO DECEDT OF CMG 1520	22	DETERMINATION	LOE ADDDOMA	DATE				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF AFPKUVAL	DALE				
(L32)			(L33)	DETERMINA	TION APPE	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 30, 2017

Ms. Margaret Brandt, Administrator St. Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

RE: Project Number S5372026

Dear Ms. Brandt:

On January 13, 2017, 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:

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

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

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

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

<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:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258

Email: Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 22, 2017, 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 February 22, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 13, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 13, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 02/09/2017 FORM APPROVED OMB NO. 0938-0391

FRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 [744] ID [744] ID [744] ID [745] SUMMARY STATEMENT OF DEFICIENCIES [746] REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 309 SS=D FOR HIGHEST WELL BEING 483.24 483.25 (k)(I) PROVIDE CARE/SERVICES FOR HIGHEST would be a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards services, consistent with repressional standards services and services, consistent with professional standards			245372	B. WING	i		01/	13/2017
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 309 SS=D 483.24 A83.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards s			CENTER			1219 SOUTH RAMSEY	•	
The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 309 483.24, 483.25(k)(i) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 000	INITIAL COMMENT	ΓS	F(000			
revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 309 SS=D FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards		signature is not req page of the CMS-29 submission of the F	uired at the bottom of the first 567 form. Electronic POC will be used as					
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards		revisit of your facilit validate that substa regulations has bee your verification. 483.24, 483.25(k)(l)	y may be conducted to intial compliance with the en attained in accordance with PROVIDE CARE/SERVICES	F3	309			1/20/17
 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards 		Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste	andamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's					
residents who require dialysis receive such services, consistent with professional standards		(k) Pain Manageme The facility must en provided to residen consistent with prof the comprehensive	sure that pain management is ts who require such services, essional standards of practice, person-centered care plan,					
care plan, and the residents' goals and		residents who requiservices, consistent of practice, the common care plan, and the r	ire dialysis receive such t with professional standards aprehensive person-centered residents' goals and	IATURE .				(X6) DATE

Electronically Signed 02/08/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any deticiency statement ending with an asterisk (*) denotes a deticiency 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245372	B. WING		01/1	3/2017
	PROVIDER OR SUPPLIER	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	preferences. This REQUIREME by: Based on observa review the facility famonitor a scabbed foot for 1 of 4 resion non-pressure skin Findings include: R11's quarterly Mirassessment dated Interview for Menta indicating severe of unstageable press assistance with be on/off unit, walk in eating, and person including diabetes R11's care plan las Alteration in skin in on 2nd toe left foot On 1/12/17, at 7:58 was observed provulcer on R11's 2nd assistant (NA)-A w After cleansing har who was seated or room. R11 was obon the top of her lenew". NA-A could scabbed area on to present though ver (1/10/17) while ass RN-A responded,	NT is not met as evidenced tion, interview, and document ailed to identify, assess, and area located on top of the left lents (R11) reviewed for conditions. nimum Data Set (MDS) 11/1/16, included a Brief al Status (BIMS) score of 7 ognitive impairment, 1 ure ulcer (PU), extensive d mobility, transfer, locomotion room/corridor, dressing, al hygiene and diagnosis mellitus.	F 309	St. Luke s Lutheran Care Center policy and procedure for Skin Ulcer Assessment, Prevention and Management is well defined. In this isolated incident, NA-A did not follow facility s protocol for promptly report new open area to charge nurse and Resident Care Coordinator. On 1/12/17, the RN Resident Care Coordinator re-educated NA-A regardacility s expectation for reporting ropen areas; NA-A stated understant R11 s open area on top of left foot treated by cleansing, applying bacit ointment and Telfa dressing daily. 1/31/17, the open area was healed. All Nursing Department staff receiv training on the facility s policy and procedure for Skin Ulcer Assessment Prevention and Management upon including instructions for direct care to immediately report to the charge and/or RN Resident Care Coordinated areas or signs of breakdown or pressure. A copy of this policy and procedure has been placed in the direport book at each station for all lic staff and nursing assistants to revisitiate. Per facility protocol, every resident have a full body skin audit complete upon admission and weekly on an ongoing basis by licensed staff. Or	w the orting a d/or arding new iding. was racin On ee ent, hire e staff nurse tor any laily censed ew and will ed	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		SURVEY PLETED
		245372	B. WING		01/	13/2017
	PROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	of R11's left foot wi was removed durin the wound started in pressure to the are and then measured the center of the wo centimeters (cm) be surrounding the op 0.5 cm. RN-A then Bacitracin and a test the treatment to R1 gloves and cleansin. When interviewed 8:10 a.m., RN-A concepted staff to rest top of R11's left foot. When interviewed stated when a new are expected to infimmediately. NA-A weekly skin audit puthen urse. NA-A concepted area on top resent on 1/10/17 the resident's show reported. When interviewed director of nursing staff identify new should be to report. The policy titled, Sk Prevention and Maincluded: Direct careport to the charge.	th wound cleanser. The scab of cleansing and subsequently to bleed. RN-A applied a until the bleeding stopped of the wound. The open area in bound measured 0.2 y (x) 0.2 cm, with pink edges en area measuring 0.5 cm x of dressed the wound with larged and the second the completed of the second the second the completed of the second the secon	F 309	monthly basis, the Director of Nu her designee will randomly audit care staff during cares, noting if r areas are reported to charge nursely. RN Resident Care Coordinators of auditing will guide future comp monitoring and training. In additional results will be summarized at the Quality Assessment and Assuran Committee Meeting. After 1 year Quality Assessment and Assuran Committee will re-evaluate the new frequency for continued compliar monitoring. The Director of Nursing is responding to a property overall compliance with this regulation.	direct new open se and/or Results liance on, the quarterly ce t, the ce eed and ace	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245372	B. WING		01/1	3/2017
	PROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 F 465 SS=C	SAFE/FUNCTIONAE ENVIRON (h) Other Environm The facility must presanitary, and comforesidents, staff and (h)(5) Establish poliapplicable Federal, regulations, regardiand smoking safety non-smoking residents and smoking residents review, the facility faceiling was maintain manner. This had the 75 residents who rekitchen. Findings include: During the initial too on 1/9/17, at 6:40 p florescent lamps, lothe food tray prepart to have brown, thick cover. The circulation resulted in movement lamp covers was creflorescent tube belocity.	ental Conditions ovide a safe, functional, ortable environment for the public. cies, in accordance with State, and local laws and ng smoking, smoking areas, or that also take into account ents. NT is not met as evidenced cion, interview, and document ailed to ensure the kitchen ned in a sanitary and clean ne potential to affect any of the acceive meals from the dietary exceive meals from the dietary described above the stove, and ration area that were observed and ration area that were observed acceive the decribed acceived to the debris. One of the acked 10 inches revealing the own.	F 309	On 1/12/17, Building Services staff members cleaned and used silicone to secure the plastic areas covering kitchen ceiling tiles. Also, all light fix in the kitchen were washed. A polic kitchen ceiling and light cleaning and maintenance was established to pro a safe, clean environment. On 1/30/17, Culinary Services staff received instruction on policy for cle kitchen ceiling and light fixtures. Or 1/12/17, Building Services Departments staff received instruction on policy for monitoring and maintaining kitchen and light fixtures. The facility received approval from it governing board to replace the kitche ceiling tiles and light fixtures. Contra	e caulk the ktures by for d omote aning ent or ceiling ts ien	1/30/17
	The ceiling was obs	served to have twelve inch tiles		are currently giving bids with plan to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245372	B. WING			01/1	13/2017
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	were covered with a wrap. There were s throughout the kitch tiles was cracked, to were 12 inch areas completely missing stained tile below. If there was a noticeal cracked loose plast what appeared to bowhich was unfinished. During a tour with the on 1/12/17, at 7:27 ceiling was in need covers above the stable were soiled ar When questioned if the FSD confirmed the ceiling. During a interview with the ceiling. During a interview with the ceiling.	ceiling. Several of the tiles a white light weight plastic everal areas of the ceiling hen were the plastic over the orn, and hanging loose. There where the plastic was revealing a dark brown throughout the kitchen ceiling ble attempt to repair the ic covering by application of e a thick layer of spackle ed. The food service director (FSD) a.m., the FSD verified that the of repair, and the lighting tove and food preparation and needed to be cleaned. There was a plan for repair, there was no plan to repair with the environmental director 11:43 a.m. ED confirmed that in to repair the ceiling in the steed for kitchen repairs and	F 4	65	the ceiling tile replaced. On a monthly basis, the Building Sc Director or his designee will monito cleaning/maintenance of kitchen ce and lights to assure compliance wit policy. Results of auditing will guid future compliance monitoring and the lin addition, the results will be summated the quarterly Quality Assessment Assurance Committee Meeting. All year, the Quality Assessment and Assurance Committee will re-evaluated and frequency for continued compliance monitoring. The Administrator is responsible for overall compliance with this regulated. Completion Date:	eiling th e raining. narized t and ter 1 ate the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

F9372026

PRINTED: 02/09/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245372 B. WING 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER **BLUE EARTH. MN 56013** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey. St. Lukes Lutheran Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or

TITLE

(X6) DATE

Electronically Signed

02/07/2017

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY MPLETED
		245372	B. WING	÷	01	/11/2017
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 000	Angela.Kappenmai <mailto:angela.kap (11)="" (111)="" 1.="" 1969="" 1975="" 2.="" 2005="" 3.="" a="" actual,="" and="" as="" base<="" basement,="" be="" building="" co="" construction.="" construction;="" correct="" corrected="" deficiency="" deficit="" description="" determine="" fire="" following="" for="" fully="" has="" height,="" if="" ii="" in="" info="" mus="" name="" no="" of="" one-story="" or="" oresponsible="" original="" plan="" pr="" properties="" sprinkler="" td="" the="" to="" type="" was=""><td>state.mn.us itiney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. uke's Lutheran Care Center is follows: g was constructed in 1963, is has a partial basement, is rotected, and was determined 1) construction; addition is one-story in height, is fully fire sprinkler protected, addition is one-story in height, is fully fire sprinkler protected</td><td>K</td><td>000</td><td></td><td></td></mailto:angela.kap>	state.mn.us itiney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. uke's Lutheran Care Center is follows: g was constructed in 1963, is has a partial basement, is rotected, and was determined 1) construction; addition is one-story in height, is fully fire sprinkler protected, addition is one-story in height, is fully fire sprinkler protected	K	000		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245372	B. WING	_		01/	11/2017
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 293 SS=F	The 2008 mechanic one-story in height, sprinkler protected, Type II (111) construction as allowed Fire Protection Ass Life Safety Code (Lealth Care Occup). The facility has a find detection in the cort to the corridors, where department not the corridors, where department not the care occup. The facility has a care census of 75 at times NFPA 101 Exit Signage 2012 EXISTING Exit and directional accordance with 7. also served by the consumer of the corridors with 19.2.10.1 (Indicate N/A in one with less than 30 octravel is obvious.) This STANDARD is Based on observed failed to ensure that displayed in accord practice could affect Exit Signage 2012 EXISTING Exit and directional	cal building addition. It is has no basement, is fully fire and was determined to be of auction. The being surveyed as one in the 2012 edition of National ociation (NFPA) Standard 101, SC), Chapter 19 Existing funcies. The alarm system with smoke ridors and in all spaces open ich is monitored for automatic iffication. The apacity of 89 beds, and had a e of the survey.	K 2	293	1. "Not An Exit" signs were ordered placed on the east dietary and the Front Porch doors indicating these two doors are not exits. 2. This was completed on 1-18-20. 3. St. Luke's Lutheran Care Center Building Services Director ordered and installed these two signs. The signs of the signs	that)17 er	1/18/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245372	B. WING			01/	11/2017
	PROVIDER OR SUPPLIER	CENTER		12	REET ADDRESS, CITY, STATE, ZIP CODE 19 SOUTH RAMSEY LUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 293	also served by the system.19.2.10.1 (lexisting occupancing where the line of existing occupancing where the line of existing occupancing where the line of existing in the service of the close to the outsing the Front Porch are the Front Porch are the Front Porch are the Front Porch are the first deficient praction. These doors needs the Front Porch are the service of the close the first protection of the close the service of th	emergency lighting Indicate N/A in one-story es with less than 30 occupants xit travel is obvious.) DE: ween 10:00 AM and 2:00 PM servation revealed the doors de from the East Diatary and e not designated as exits. It to be marked "No Exit". It tice was verified by the Facility tor. In System - Installation Installation Installation Installation Installation In FPA 13, Standard for the Inkler Systems. Instruction, alternative protection In in specific areas where state Is prohibit sprinklers. Illers are not required in clothes	К2		Building Services Director or his designee will monitor facto assure that all doors not desexits have a "Not An Exit" sign.	signated as	1/18/17

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	MULTIPLE CONSTRUCTION JULDING 01 - MAIN BUILDING 01		(X3) DATE SURVE COMPLETED	
		245372		B. WING			11/2017
	PROVIDER OR SUPPLIER	J _I		S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY BLUE EARTH, MN 56013	1 017	11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	ION SHOULD BE THE APPROPRIATE	
K 351	obstructions that coaccordance with NI could affect 40 of the Spinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automatic accordance with NI Installation of Sprin In Type I and II conmeasures are permisprinkler protection or local regulations In hospitals, sprinkler closets of patient slof the closet does in sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 FINDINGS INCLUE On facility tour betwon 01/11/2017, obscurtains were observations were observations where observations were observations where the 1/2 inchopen weave panel) causing an obstruction deflector.	t fire sprinklers were kept from buld effect the operation in FPA 13. This deficient practice he 75 residents. Installation Installation In the protected throughout by an exprinkler system in FPA 13, Standard for the kler Systems. Struction, alternative protection hitted to be substituted for in specific areas where state prohibit sprinklers. Here area are not required in clothes eeping rooms where the area not exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 17, 9.7.1.1(1)	K	351	divider curtain that did not have the required mesh at the to the curtain. 2. This was completed on 1-18-20. 3. The St. Luke's Lutheran Care On the department staff will monitor divider curtains on an ongoing basis to assure that divident curtains meet requirements and are not causing an obstruction to fire sprinkler deflector.	017 Center facility ider	

PRINTED: 02/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245372 B. WING 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PRFFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 351 | Continued From page 5 K 351 Maintenance Director. K 363 NFPA 101 Corridor - Doors K 363 1/17/17 SS=D Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, This STANDARD is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245372	B. WING			01/11/2017	
ST LUKE		ATEMENT OF DEFICIENCIES	ID	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 219 SOUTH RAMSEY SLUE EARTH, MN 56013 PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
K 363	failed to ensure docopenings were in o deficient practice or residents. Corridor - Doors 2012 EXISTING Doors protecting corequired enclosures hazardous areas slas those constructs core wood, or capa 20 minutes. Doors compartments are passage of smoke. a means suitable for There is no impedit doors. Clearance be floor covering is no latches are prohibit corridor doors and or combustible mat complying with 7.2. devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6. Door frames shall be or other materials in the smoke compart window assemblies sprinklered compare restrictions in area frames in window at 19.3.6.3, 42 CFR Pand 485	tion and interview, the Facility ors protecting corridor perable condition. This ould affect 30 of the 75 perridor openings in other than so of vertical openings, exits, or nall be substantial doors, such ed of 1-3/4 inch solid-bonded ble of resisting fire for at least in fully sprinklered smoke only required to resist the Doors shall be provided with or keeping the door closed. The tothe closing of the etween bottom of door and the exceeding 1 inch. Roller ed by CMS regulations on rooms containing flammable erials. Powered doors 1.9 are permissible. Hold open the when the door is pushed or do. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Dutch doors are permitted. The permitted is sprinklered. Fixed fire are allowed per 8.3. In the there are no or fire resistance of glass or	К3	63	1. On 1-11-17, St. Luke's Luthera Center's Building Services Director contacted an electrician order and install a door magnet hold open on Room 509 was installed and completed on 1-17-2017. 2. This was completed on 1-17-20 3. The St. Luke's Lutheran Care Completed on 1-18 designee will monitor facil doors to assure that the door magnet hold open and clos working properly.	to This 17. enter	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
		245372	B. WING_		01/1	1/2017
	PROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP 1219 SOUTH RAMSEY BLUE EARTH, MN 56013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
K 363	etc. FINDINGS INCLUI	automatics closing devices,	K 30	53		
K 372	on 01/11/2017, obsclosing device on Eneeding repair. This deficient pract Maintenance Direct	ervation revealed the self Door #509 was observed ice was verified by the Facility	K 3	72		1/13/17
SS=F	Construction 2012 EXISTING Smoke barriers shafire resistance ration be permitted to terr Smoke dampers ar penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This STANDARD is Based on observa facility failed to mai construction that m 101 - 2012 edition, (1). This deficient	s not met as evidenced by: tion and staff interview, the ntain smoke barrier walls eet the requirements of NFPA Sections 19-3.7.3 and 8.6.7.1. practice could affect 75 of 75 ng smoke to propagate from		1. On 1-13-2017, The St. Care Center Building Serv Director used approved open penetrations around conduits at the C Wing St. This was completed on 3. The St. Luke's Lutherar	rices fire caulk to fill Smoke Barrier. 1-13-2017	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED				
		245372	B. WING			01/	11/2017			
	PROVIDER OR SUPPLIER S LUTHERAN CARE	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013			•				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 372	Construction 2012 EXISTING Smoke barriers shafire resistance rations shall be permitted to Smoke dampers ar penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechain REMARKS. FINDINGS INCLUE On facility tour betwon 01/11/2017, obspenetrations around lay-in ceiling tiles in Note: All smoke barensure compliance.	all be constructed to a 1/2-hour g per 8.5. Smoke barriers terminate at an atrium wall. e not required in duct ducted HVAC systems where ler system is installed for ints adjacent to the smoke anical smoke control system DE: Veen 10:00 AM and 2:00 PM servation revealed delectrical conduits above the the C-Wing Smoke Barrier.	K 3	772	or his designee will monitor this a other smoke barriers for any open penetrations and use approfire caulk to fill open penetrations.					



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted January 30, 2017

Ms. Margaret Brandt, Administrator St. Lukes Lutheran Care Center 1219 South Ramsey Blue Earth, MN 56013

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5372026

Dear Ms. Brandt:

The above facility was surveyed on January 9, 2017 through January 13, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

Licensing and Certification Program Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 02/09/2017

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 00116 01/13/2017

		00116		B. WING	·····	01/13/2017			
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
ST LUKE	S LUTHERAN CARE	CENTER		OUTH RAMSEY EARTH, MN 56013					
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE			
2 000	Initial Comments			2 000					
	*****ATTE	NTION*****							
	NH LICENSING	CORRECTION	ORDER						
	In accordance with 144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall with a schedule of the Minnesota Depart	ction order has y. If, upon reir iency or deficie ected, a fine for be assessed ir ines promulga	s been issued aspection, it is encies cited r each violation accordance ted by rule of						
	Determination of whe corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	compliance with rule provided alle number indens several item the items will be ack of company item of multiment of a fine	h all at the tag icated below. as, failure to be considered oliance upon ti-part rule will even if the item						
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliar It a written requ hin 15 days of	nce with these uest is made to receipt of a						
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the agreement of Health	participate in naure orders cartment of Healin 14-01, availate.mn.us/divse licensing ord	onsistent with alth able at s/fpc/profinfo/inf ers are						

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/08/17 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 7 PAQX11

TITLE

(X6) DATE

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00116		B. WING		01/	13/2017
	PROVIDER OR SUPPLIER ES LUTHERAN CARE	CENTER .	1219 SOU	DRESS, CITY, S ITH RAMSEN RTH, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FO SC IDENTIFYING INFORMATI	ULL ION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department on January 9, 10, 1 surveyors of this Deabove provider and orders are issued. electronic plan of co	Ith orders being submit Although no plan of context Statutes/Rules, ple rected" in the box avaice indicate in the electropess, under the heading edate your orders will ectronically submittingment of Health. 1, 12, and 13th, 2017, epartment's staff visited the following correction that you have ers, and identify the date.	rrection ase lable for nic ng be to the d the on r	2 000			
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement, evidence by." Follow	nent of Health is docunt Correction Orders using numbers have been ota state statutes/rules umber appears in the Prefix Tag." The state ompliance is listed in the compliance is listed in the comply" portion of the state of Deficiencies column also included in violation of the state wing the surveyors find Method of Correction are rection.	far left e he umn he es the statute as Jings				

6899

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00116		B. WING		01/13/2017		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST LUKE	S LUTHERAN CARE	CENTER		ITH RAMSE ¹ RTH, MN 56				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From part PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO RECOMINNESOTA STAT MN Rule 4658.0520 Proper Nursing Carroustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain prefers to remain in This MN Requirements by: Based on observation review the facility fare.	ge 2 IRD THE HE I WHICH ST N OF CORF ERAL DEFIC R ON EACH QUIREMENT CTION FOR E STATUTE O Subp. 1 Act e; General general. A re e and treatm supervision d preference resident ass scribed in pa ing home res possible unle he attending in in bed or in bed.	EADING OF THE TATES, RECTION." THIS EIENCIES ONLY. I PAGE. TO SUBMIT A VIOLATIONS OF S/RULES. Idequate and resident must nent, personal and based on es as identified in sessment and rts 4658.0400 and sident must be out ess there is a physician that the the resident et as evidenced of and document	2 000			1/20/17	
	monitor a scabbed foot for 1 of 4 reside non-pressure skin of Findings include:	area located ents (R11) re	on top of the left					
	R11's quarterly Mini	imum Data 9	Set (MDS)					
	TET 3 quarterly Willing	mum Dala C	JOE (IVIDO)					

Minnesota Department of Health STATE FORM

PAQX11 If continuation sheet 3 of 7

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00116	B. WING		01/1	01/13/2017	
	PROVIDER OR SUPPLIER	CENTER 1219 SOU	DRESS, CITY, S TH RAMSEN RTH, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	assessment dated Interview for Menta indicating severe counstageable pressures assistance with bedon/off unit, walk in eating, and personal including diabetes of R11's care plan last Alteration in skin into on 2nd toe left foot. On 1/12/17, at 7:58 was observed proviulcer on R11's 2nd assistant (NA)-A way After cleansing han who was seated on room. R11 was obson the top of her left new". NA-A could rescabbed area on topresent though veri (1/10/17) while assist RN-A responded, "then". RN-A donne of R11's left foot with was removed during the wound started the center of the wood centimeters (cm) by surrounding the ope 0.5 cm. RN-A then Bacitracin and a tell	11/1/16, included a Brief I Status (BIMS) score of 7 cognitive impairment, 1 ure ulcer (PU), extensive I mobility, transfer, locomotion room/corridor, dressing, al hygiene and diagnosis mellitus. I reviewed 12/20/16 indicated: regrity as evidenced by ulcer a.m. registered nurse (RN)-A ding treatment to a pressure toe on the left foot; nursing as also present in the room. ds, RN-A approached R11 a shower chair located in her served to have a scabbed area at foot; RN-A stated, "That's not confirm how long the p of R11's left had been fied it was noted 2 days prior sting R11 with her shower. It should have been reported d gloves and cleansed the top th wound cleanser. The scab g cleansing and subsequently to bleed. RN-A applied a until the bleeding stopped the wound. The open area in bound measured 0.2 (x) 0.2 cm, with pink edges en area measuring 0.5 cm x dressed the wound with fa pad. RN-A then completed 1's left 2nd toe after changing	2 830				

6899

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			DATE SURVEY COMPLETED	
ST LUKES LUTHERAN CARE CENTER 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 1219 SOUTH RAMSEY BLUE EARTH, MN 56013 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			00116	B. WING		01/1	3/2017	
ST LUKES LUTHERAN CARE CENTER BLUE EARTH, MN 56013 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OATE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ST LUK	ES LUTHERAN CARE	CENTER	_				
	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE	
When interviewed on 1/12/17, at approximately 8:10 a.m., RN-A confirmed she would have expected staff to report the scabbed area on the top of R11's left foot when first identified. When interviewed on 1/12/17, at 8:29 a.m. NA-A stated when a new skin issued is identified, staff are expected to inform the charge nurse immediately. NA-A further stated that R11 had a weekly skin audit performed every Thursday by the nurse. NA-A confirmed the reddened, scabbed area on top of R11's left foot had been present on 1/10/17 (Tuesday) when assisting with the resident's shower but it had not been reported. When interviewed on 1/13/17, at 11:21 a.m. the director of nursing (DON) confirmed that when staff identify new skin conditions the expectation would be to report to the charge nurse right away. The policy titled, Skin Ulcer Assessment, Prevention and Management revised 3/07, included: Direct care staff are to immediately report to the charge nurse and/or RCC (resident care coordinator) any red areas or signs of breakdown or pressure. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor non-pressure skin conditions present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830	When interviewed of 8:10 a.m., RN-A corexpected staff to retop of R11's left food. When interviewed of stated when a new are expected to informediately. NA-A weekly skin audit pethe nurse. NA-A conscabbed area on topresent on 1/10/17 the resident's shown reported. When interviewed of director of nursing (staff identify new skin would be to report to the charge care coordinator) and breakdown or pressure skin of skin conditions pressure skin conditions pressure skin conditions pressure skin conditions pressure with the TIME PERIOD FOR	on 1/12/17, at approximately infirmed she would have port the scabbed area on the t when first identified. On 1/12/17, at 8:29 a.m. NA-A skin issued is identified, staff orm the charge nurse further stated that R11 had a erformed every Thursday by infirmed the reddened, p of R11's left foot had been (Tuesday) when assisting with er but it had not been (DON) confirmed that when a conditions the expectation of the charge nurse right away. In Ulcer Assessment, in agement revised 3/07, are staff are to immediately enurse and/or RCC (resident in the property of the conditions and/or non-pressure is staff on the need to monitor conditions and/or non-pressure sent on residents upon cility. The director of nursing udit to monitor staff expolicy.					

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
			A. BUILDING:									
		00116	B. WING		01/1	3/2017						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
ST LUKES LUTHERAN CARE CENTER 1219 SOUTH RAMSEY BLUE EARTH, MN 56013												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE						
21685	Continued From pa	ige 5	21685									
21685	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			1/30/17						
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation lealth, comfort, safety, and esidents according to a written se and repair program.										
	by: Based on observati review, the facility f ceiling was maintai manner. This had t	ent is not met as evidenced ion, interview, and document ailed to ensure the kitchen ned in a sanitary and clean he potential to affect any of the eceive meals from the dietary		Corrected.								
	on 1/9/17, at 6:40 p florescent lamps, lo the food tray prepa to have brown, thic cover. The circulati resulted in movement	ur of the kitchen service area o.m., there were eight 6 foot ocated above the stove, and ration area that were observed k, fuzzy debris on the lamp on of air in the kitchen, ent of the debris. One of the racked 10 inches revealing the ow.										
	covering the entire were covered with a wrap. There were s throughout the kitch	served to have twelve inch tiles ceiling. Several of the tiles a white light weight plastic several areas of the ceiling nen were the plastic over the corn, and hanging loose. There										

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00116	B. WING		01/1	3/2017					
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE								
ST LUKES LUTHERAN CARE CENTER 1219 SOUTH RAMSEY BLUE EARTH, MN 56013											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE						
21685	were 12 inch areas completely missing stained tile below. It there was a noticeal cracked loose plast what appeared to be which was unfinished. During a tour with the on 1/12/17, at 7:27 ceiling was in need covers above the stable were soiled at When questioned if the FSD confirmed the ceiling. During a interview of (ED) on 1/12/17, at there was not a plakitchen. A policy was request maintenance; one of the ceiling of the centre	where the plastic was, revealing a dark brown Throughout the kitchen ceiling able attempt to repair the cic covering by application of e a thick layer of spackle ed. The food service director (FSD) a.m., the FSD verified that the of repair, and the lighting tove and food preparation and needed to be cleaned. If there was a plan for repair, there was no plan to repair with the environmental director 11:43 a.m. ED confirmed that in to repair the ceiling in the	21685								