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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QICC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00571

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245067**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/25/2018** (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)
07/27

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Eva Loch, Unit Supervisor — 10/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 10/18/2018 (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
01/01/1967
(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
10/04/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245067

October 18, 2018

Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

Dear Administrator:

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 September 4, 2018 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18, 2018

Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067029

Dear Administrator:

On August 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26, 2018. 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 September 25, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 7, 2018 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 July 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2018, effective September 4, 2018 and therefore remedies outlined in our letter to you dated August 9, 2018, 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QICC

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Facility ID: 00571

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(L1) **245067**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470618800**

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(L3) **ST LUCAS CARE CENTER**
(L4) **500 SOUTHEAST FIRST STREET**
(L5) **FARIBAULT, MN** (L6) **55021**

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 **07/26/2018** (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)
07/27

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE NE II 08/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 09/04/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2018

Mr. Joseph Gubbels, Administrator
St Lucas Care Center
500 Southeast First Street
Faribault, MN 55021

RE: Project Number S5067029

Dear Mr. Gubbels:

On July 26, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 September 4, 2018, 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 September 4, 2018 the following remedy will be imposed:

- 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 October 26, 2018 (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 January 26, 2019 (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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 On July 23 through July 26, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and	F 572		9/4/18

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

Electronically Signed | 08/15/2018

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
	245067	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 572	Continued From page 1 responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident bill of rights (BOR) were provided verbally to all facility residents. This had the potential to affect all 72 residents in the facility. Findings include: On 7/24/18, at 2:48 p.m., seven residents (R34, R1, R22, R32, R33, R35, R30) were present at a resident council meeting held by surveyor. When questioned if the resident BOR had been reviewed, the residents present stated the rights had not been reviewed and asked where they were located. On 7/26/18, at 3:24 p.m., a review of the resident council minutes from 7/2017-7/2018 confirmed the resident BOR were not discussed during the resident council meetings. During an interview with the activity director (AD) on 7/26/18, at 1:42 p.m., the AD verified the resident's rights were not discussed at resident council meetings, although had occasionally mentioned the location of the resident BOR in the facility. A facility policy dated 8/2014, Resident Council Meetings and Resident Concerns, indicated,	F 572	F572 Notice of Rights and Rules Immediate corrective action: The Activity Director and backup were educated on the Resident Council Policy on _8/9/18__which includes sharing the Bill of Rights information at the meetings. Action as it applies to others: The Policy and Procedure for Resident Council was reviewed and remains current. All residents receive a copy of their BOR upon admission. Resident Rights will be reviewed at each Resident Council meeting, starting with the next meeting which is scheduled for __8/23/18_____. At the beginning of each meeting, 2 different Rights will be discussed on a rotation which will repeat once all have been reviewed. Date of completion: __9/4/18_____. Recurrence will be prevented by: Audits will be conducted of each Resident Council meeting contents to assure the Resident Bill of Rights have been reviewed. This will be done x 90 days and results shared with the facility QAPI Committee for input on the need to continue the audits. The correction will be monitored by: Administrator/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245067	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUCAS CARE CENTER	500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021

(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 572	Continued From page 2 "staff will read and review with the Resident Council bullet points from the Resident Bill of Rights at each monthly meeting."	F 572		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to send a notice of bed hold to	F 625	F625 Bed hold Immediate corrective action:	9/4/18

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	245067	A. BUILDING _____ B. WING _____	07/26/2018

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F 625	Continued From page 3 family/representative for residents who were emergently transferred out the facility for 3 of 3 residents (R2, R39, R66) reviewed for hospitalization. Findings include: R2's Admission Record dated 2/1/18, included diagnoses of bilateral myopia (near sightedness), bilateral regular astigmatism (a defect of the vision system) and unspecified encephalopathy (disease that affects the brain). Nursing progress note dated 7/4/18, indicated R2 was transferred to the hospital per non emergency transport for rectal bleeding. Nursing progress note dated 7/10/18, indicated resident was readmitted to the facility transported via stretcher. Review of the record revealed lack of evidence that a bed hold notice had been given to R2 or R2's family representative. R39's Admission Record dated 5/30/18, included the diagnoses of generalized anxiety, hypothyroidism, insomnia, and hypertension. Nursing progress note dated 6/2/18, indicated R39 was transferred to the hospital for symptoms of confusion by her daughter. A nursing progress note dated 6/3/18, indicated R39 may have had a stroke. A nursing progress note date 6/5/18, indicated resident had returned to the facility. Review of the record revealed lack of evidence that a bed hold notice had been given to R39 or R39's family representative.	F 625	The beds were held for Residents #_2, 39, and 66 even though the required paperwork was not provided to the resident and resident representative. Action as it applies to others: The Policy and Procedure for providing bed hold information for the resident and resident representative remains current. All licensed nurses and social services will be re-educated on _8/23/18___on the requirement to provide bed hold notices to the resident and resident representative when resident is transferred to the acute care setting. Date of completion: _9/4/18____ Recurrence will be prevented by: Audits of providing bed hold notices with hospital transfers will be conducted with each transfer x90 days and reviewed in Quality Conference daily. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. The correction will be monitored by: DON/Social Services/Adm./designee	

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During an interview on 7/24/18, at 2:07 p.m. the health information clerk (HIC) was unable to locate bed hold notices in R2's and R39's records. HIC stated nursing should be doing this at the time of transfer to the hospital.

On 7/25/18, at 12:24 p.m. registered nurse (RN)-A stated the nurse on the floor should have completed the bed hold at the time of transfer or leave. On 7/25/18, at 1:25 p.m. the administrator stated they had a policy in the admissions packet and residents were given that at time of admission. The administrator further stated if the HIC did not find a bed hold signed for R2 and R39, that they did not have one completed.

R66's Admission Record dated 7/25/18, included the diagnoses of left artificial knee replacement.

Nursing progress note dated 6/21/18, indicated R66 had a follow up appointment with a surgeon to evaluate progress of left knee due to swelling and inability to bear weight. Determined left patella tendon rupture with emergency surgery to be performed on 6/25/18, at 10:45 a.m.

The Discharge Summary from the acute care setting signed by the provider on 7/2/18, indicate R66 was admitted on 6/25/18, and discharged back to the facility on 7/2/18. Review of the record revealed a lack of evidence that a bed hold notice had been given to R66 or R66's family representative.

During an interview with the director of nursing (DON) 7/25/18, at 12:24 p.m., the DON confirmed that a bed hold notice should have been given to

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F 625	Continued From page 5 R66 or R66's family representative and it was not. The facility's undated Bed Hold and Readmission Policy, indicated "The facility will offer a bed-hold to private pay, Medicare and/or managed care resident when absent for acute care hospital stays or therapeutic leaves."	F 625		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly assess and implement interventions to address the psychosocial needs 1 of 1 residents (R226) reviewed for mood/behavior (depression). Findings include: R226's Admission Record for admission date of 7/5/18, indicated a diagnosis of encounter for other specified aftercare, major depressive disorder, end stage renal disease, post pancreatic transplant and multiple others. During an initial interview with R226 on 7/23/18,	F 740	F740 Behavioral Health Services Immediate corrective action: Monitoring for side effects, effectiveness, mood, and behavior for antidepressant administration for Resident # 226 was added to the EMAR and Care Plan on _7/24/18____. An individualized plan for resident #226 addressing her psychosocial needs regarding chronic kidney disease, dialysis, back tumor newly diagnosed, and family loss due to living arrangement changes was developed on _7/24/18____. and includes non-pharmacological interventions as well.	9/4/18

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F 740	Continued From page 6 at 6:37 p.m. she stated she has been sad and has been crying a lot since she came to the facility and that she wants to go home. During a conversation with R226 on 7/24/18, in the a.m. (unsure of exact time) R226 stated that she has been to this facility in the past, but this time, she is much more sad and weepy. She visibly got tears to her eyes as she said this. She also stated she is having back pain and is getting medication for this. She did not know if she was taking medication for depression and stated the facilty had not discussed this with her nor had the dialysis unit, where she went three times a week. R226 further explained that she had a history of a pancreatic and kidney transplants and her kidneys have failed. She stated, "I thought this kidney would last the rest of my life". R226 stated she wanted to go home further explaining that she lives with her spouse, but that she had gown children and grandchildren living with her the past few months and they got a place of their own and moved out while she was in the hospital. On 7/24/18, at 3:30 p.m. the licensed social worker (LSW) stated R226 was having a hard time with the fact that most of the family was outside the facility. She wanted to be nearer to her family. The LSW stated R226 seemed down with this admission (had been at the facility in the past) and she wanted to go home. She was not sure if the resident was on an antidepressant medication without looking. On 7/25/18, at 7:41 a.m. R226 was in bed, awake and stated she was waiting for staff to help her get up. She stated she may go home this Friday. She missed being home, missed her family and grand children. She verbally expressed sadness	F 740	Action as it applies to others: The Policy for monitoring psychopharmacological medications was reviewed and remains current. All residents receiving a psychopharmacological medication will be reviewed to assure the monitoring for side effects, effectiveness, mood and behavior has been included on the Care Plan and EMAR. Individualized plans for those residents with depression, grief, loss or other psychosocial needs will be developed by the ID Team led by the Social Services Director and input from psychology. All licensed nurses and social services will be re-educated on _8/23/18___. on the Policy for psychopharmacological medications. Date of completion: __9/4/18____. Recurrence will be prevented by: An audit of 3 residents receiving psychopharmacological medications will be conducted weekly x 90 days to assure effective monitoring is in place, to include individualized plans for addressing depression, grief, and loss as well as monitoring effectiveness, side effects, mood and/or behavior. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Social Services/designee	

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and how she cried more often stating: "It seems that I am crying a lot".

During a call to the Owatonna Mayo Dialysis unit, on 7/25/18, at 7:41 a.m. the dialysis unit registered nurse stated R226 had been having episodes of weepiness and had stated she wanted to stop dialysis. The RN stated they have talked to her and explained that stopping dialysis would shorten her life. RN further explained that R226's family wanted her to keep going to dialysis.

On 7/25/18, at 8:13 a.m. during an interview with the physical therapy assistant (PTA) she stated that a couple of weeks ago, R226 was able to walk about 40 feet and had been progressing and now could hardly walk 4 feet and her balance was zero. PTA stated R226 has been using a mechanical lift for transfers and that R226's spouse was aware of the decline. PTA further stated R226 had a tumor on her spine resulting in fractures to the lumbar (L)vertebrae of L3 and L4. PTA thought R226 was going to get radiation to her back in the future and stated that nursing was aware of the decline in physical ability.

During an interview with the director of nursing (DON) on 7/25/18, at 8:48 a.m. he recalled that R226 had a note in the discharge summary from the hospital about a benign tumor in her back and did not think it required treatment. DON was sure the mass was in the referral document they got at the time of admission and had been aware of this diagnosis. It was not listed on the medical diagnosis list for R226.

There was a doctor discharge note found in the medical record dated 7/5/18, "to see follow up

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neuro for back after 8/6/18 when vancomycin (antibiotic being given for VRE :Vancomycin-resistant Enterococci-blood stream infection at dialysis) is completed".

On 7/25/18, at 9:15 a.m. RN-A stated she had sent a weekly update to the doctor per her email, dated the week of 7/16/18, that indicated the change in physical mobility, but not mood or behavior.

On 7/25/18, at 10:27 a.m. the LSW stated that if a medication was given as needed and not scheduled they should be monitoring mood. She further explained that for scheduled anti-depressant medication that the staff should be monitoring mood and behavior. They would notify the physician if there was a change in resident behavior.

On 7/25/18, at 10:44 a.m. the health information clerk stated that monitoring for behaviors, mood, effect/side effect should be in the orders at the time of admission. She could not explain why this was not done.

On 7/26/18, at 11:35 a.m. the DON stated he would expect monitoring for mood and behavior to be a part of the orders and he could not explain why this was not done for R226. He further explained mood/behavior/effect/side effect monitoring should have been added "ASAP" after admission. He could not explain why monitoring for R226 had been missed.

The depression scale assessment (PHQ-9) dated 7/9/18, indicated a 2 (Minimal Depression).

The Medication Review Report dated 7/26/18,

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indicated the resident was on Sertraline HCL Tablet 50 mg (1) tablet one time a day for depression. Review of the medication administration record since admission of 7/5/18, did not indicate any monitoring of mood, behavior, tearfulness or other signs of depression or changes in mood. There was no behavior or mood tracking found in the electronic record. There was no evidence progress notes in the record related to her mood/behavior.

In the medical record, dated 7/18/2018, at 15:51 the "Care Area Assessment (CAAs)" indicated R226 was on medication for depression, she was being monitored by staff for overall effectiveness and side effects. This included her mood and behavior documentation, a monthly pharmacy review of her medications and the overall effectiveness of psychotropic medications. While the CAA was addressed for depression, they did not address her psychosocial needs regarding her chronic kidney disease and need for dialysis, a newly diagnosed back tumor, loss of family in her home by having her children and grand children moving out while she was in the hospital, and the decline in physical condition since admission.

The resident plan of care dated 7/13/18, indicated "I am taking Psychotropic Medications for depression", The goal for R226 indicated: "I want to free of side effects and stable in my illness". The interventions indicated: "Monitor for increase in depressive symptoms such as tearfulness" and "Staff will observe for changes in my condition" and "Staff will observe for side effects of these drugs: antidepressant". While the individualized plan of care addressed her depression, there was no individualized plan to address psychosocial

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F 740	Continued From page 10 needs regarding chronic kidney disease and need for dialysis, a newly diagnosed back tumor, loss of family in her home by having her children and grand children moving out while she was in the hospital, and the decline in physical condition since admission. A policy titled "Psychopharmacologic Medication Assessment and Review" revised Nov 2017, identified antidepressants as psychopharmacologic medications and stated: 5. All residents on psychopharmacological medicaiton require the resident specific reason for its use monitored. 6. All psychopharmacological medicaiton must have care planned non-psychopharmacological interventions attempted prior to administering the medication. 7. Side Effect monitoring will be completed on each type of psychopharmacological medication used by individual residents".	F 740		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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	F 761		9/4/18

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F 761	Continued From page 11 personnel to have access to the keys. §483.45(h)(2) 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 tuberculin solution was dated when opened to ensure expired product was not administered on 2 of 3 units (70's and 90's) reviewed for medication storage. This had the potential to affect staff or residents who could have been tested with the remaining, potentially expired 16 doses. Findings include: On 7/23/18, at 3:52 p.m. a tour was completed of the unit 70's medication room with licensed practical nurse (LPN)-C. The medication storage refrigerator in the medication room was inspected and contained one opened box, and one opened vial of Aplisol Tuberculin derivative. The box identified the vial contained enough product for "10 tests" and had approximately 0.8 milliliters visible solution remaining inside. LPN-C confirmed the Aplisol had a (manufacturer's) expiration date of 10/19, had no open date, and staff would have no way of knowing if it was being used longer than 30 days after opening. A pharmacy placed label was affixed which identified the solution name, along with a 'fill' date	F 761	F761 Medication labeling and storage Immediate corrective action: The vials of Tubersol identified with no open date were discarded immediately. Action as it applies to others: The Policy and Procedure for labeling and storage of medications which includes dating when opened remains current. All licensed nurses will be re-educated on the Policy for labeling and storage of medications and the frequency of checking medication refrigerators, med rooms and medication carts on _8/23/18____. Date of completion: __9/4/18____. Recurrence will be prevented by: Audits of medication storage and labeling will occur 3x weekly x90 days on various shifts and units to assure compliance with the Policy. The results of these audits will be reviewed by the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Staff Development/designee	

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F 761	Continued From page 12	F 761		

on the label printed as 4/7/18, however, neither the box nor vial of opened solution were dated to demonstrate a date when they were opened and/or when they expired.

On 7/23/18, at 4:13 p.m. a tour was completed of the unit 90's medication storage room with the director of nursing (DON). The medication storage refrigerator in the medication room was inspected and contained two opened boxes, and two opened vials of Aplisol Tuberculin derivative. The vials contained enough product for "10 tests" and the two vials had approximately 1.4 milliliters of visible solution remaining. Pharmacy placed labels were affixed to both vials which identified the solution name, along with 'fill' dates on the labels printed on 4/7/18, however, neither the boxes nor vials of opened solution were dated to demonstrate a date when they were opened and/or set to expire. The DON confirmed both vials of Aplisol had expiration dates of 10/19, no open dates, and staff would have no way of knowing if they were open longer than 30 days.

On 7/25/18, at 10:47 a.m. the DON stated the Aplisol was used for both staff and residents and facility staff should have dated the three open Aplisol vials as soon as they were opened and this had not been done. DON also explained when staff found an opened Aplisol vial without an open date written on it they should send it back to pharmacy immediately.

The packet insert inside the box dated 03/16, containing a 1 ml (10 tests) multiple dose vial of Aplisol (Tuberculin Purified Protein Derivative) included the following storage instructions: "DO NOT FREEZE: This product should be stored between 36 F and 46 F degrees and protected

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F 761	Continued From page 13 from light. Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." A facility's Medications: Storage policy dated 06/17, indicated "Stock bottles/solutions are dated when opened" and "No discontinued, outdated or deteriorated medications/solutions are available for use in this faciilty. All such medications/solutions are destroyed."	F 761		

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ST LUCAS CARE CENTER	**500 SOUTHEAST FIRST STREET** **FARIBAULT, MN 55021**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2018

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
	245067	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2018**

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The St Lucas Care Center was constructed at 5 different times.. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor are used for health care). In 1960 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and the 4 additions and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 90 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.2.7, 19.2.7) This deficient practice could affect the safety of all (35) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 07/25/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility - uneven grade outside the exit door (1909 - 1971 crossover) This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 271	K271 Discharge from exits Immediate corrective action: Uneven concrete on west exit door area has been repaired on 8/1/18 Action as it applies to others: Remind all staff to record in Tel□ s facility maintenance program any issues with concrete as observed. Date of completion: __9/4/18_____. Recurrence will be prevented by: Maintenance director will enter into Tel□s program to check qtrly. for concrete problems. The correction will be monitored by: Maintenance director, Adm., or designee will monitor for compliance.	9/4/18

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K 271	Continued From page 3 discovery.	K 271		
K 346 SS=D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.6.1.6) This deficient practice could affect the safety of all (76) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 07/25/2018, observation and documentation reviewed revealed the following: During documentation review - observed that the Fire Alarm out-of-service policy and no time reference (white-out on document) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 346	K346 Fire alarm-out of service Immediate corrective action: Fire protection systems out of service policy will be updated to include 10 hrs. of sprinkler system out of service or fire alarm 4 hrs. or more out of service, the state fire marshall will be contacted. Policy will include current fire marshall□s name and phone number Action as it applies to others: New updated policy will be included in facilities emergency plan manual. Date of completion: __9/4/18_____(date) Recurrence will be prevented by: Will be added in Tel□s program to review annually and update as needed. The correction will be monitored by: Maint. director, Adm., or designee	9/4/18
K 500 SS=D	Building Services - Other CFR(s): NFPA 101 Building Services - Other	K 500		9/4/18

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K 500	Continued From page 4 List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 101 - A.19.1.1.1.7 / NFPA 99 - 13.4.8) This deficient practice could affect the safety of all (13) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 07/25/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility - 2nd FL - unsecured communications utility panel in the resident hallway This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 500	K500 Building services Immediate corrective action: Maintenance team secured the utility panel on 2nd floor memory care unit with a lock on 7/25/18. Action as it applies to others: Complete building wide inspection completed by maint. team to check all panels for secured locks. Locks will be installed on panels as needed. Date of completion: __9/4/18_____. Recurrence will be prevented by: Maint. director will enter into Tel□s program to check qtrly. The correction will be monitored by: Maint. director, Adm., or designee	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		9/4/18

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K 914	Continued From page 5 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (76) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 07/25/2018, observation and documentation reviewed revealed the following: During documentation review - it was determine that no electrical testing had been completed or documented This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914	K914 Electrical systems, maintenance and testing Immediate corrective action: All electrical outlets will be tested by maint. team for blade and polarity testing and tension testing and replaced if deemed faulty. Action as it applies to others: Remind staff to enter any issues with outlets into Tel□s maint. program to be checked and repaired as needed. Date of completion: __9/4/18____. Recurrence will be prevented by: Maint. director will add to Tel□s program to test annually. The correction will be monitored by: Maint. director , Adm., or designee.	

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K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (76) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM	K 920	K920 Electrical equipment, power/extension cords Immediate corrective action: Immediately removed all power strips from all areas listed on statement of deficiency. Action as it applies to others: Maint. team completed a facility wide check for any other power strips that are being used inappropriately. Date of completion: __9/4/18_____. Recurrence will be prevented by: Maint.	9/4/18

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K 920	Continued From page 7 on 07/25/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility multiple occurrences of appliances connected to power-strips: (1) Basement - MUA Equipment Rm - Refrigerator; (2) Basement - Break Room - Toaster; (3) Basement - H.R. Office - Coffeemaker; (4) Basement - H.R. Office - Refrigerator; (5) 1st FL - Unit Manager Office - Refrigerator This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	director will enter into Tel□s program to inspect for power strips on a semi-annual basis. The correction will be monitored by: maint. director, Adm., or designee	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		9/4/18

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K 923	Continued From page 8 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect the safety of all (76) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:00 PM on 07/25/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility - Oxygen Room (RM 21) had no separation of cylinders and no in-room signage This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	K923 Gas equipment, cylinder and container storage Immediate corrective action: Immediately separated O2 cylinder tanks in Room 21 that are filled or empty. A sign will be put in the room indicating filled vs. empty tanks. Action as it applies to others: Maint. team checked all other O2 storage rooms for cylinders that are either filled or empty and separated them. Date of completion: __9/4/18____. Recurrence will be prevented by: Will contact northwest Oxygen company to supply facility with O2 cylinder holders to be able to keep filled vs. empty cylinders separated. Sign will be put on cylinder holder indicating full or empty tanks. Maint. director will add to Tel□s program to check qtrly for compliance. The correction will be monitored by:	

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K 923	Continued From page 9	K 923	Maint. director, Adm., or designee.	