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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TQG1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

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

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

4. TYPE OF ACTION: **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 **05/11/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 05/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/01/2015 (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
11/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/05/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245407

July 1, 2015

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

Dear Mr. Jensen:

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 May 26, 2015 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 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,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2015

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

RE: Project Number S5407023

Dear Mr. Jensen:

On April 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 2015. 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 May 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 29, 2015 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 March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 26, 2015, effective May 26, 2015 and therefore remedies outlined in our letter to you dated April 9, 2015, 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,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245407	A. Building B. Wing	5/11/2015

Name of Facility	Street Address, City, State, Zip Code
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0242 Reg. # 483.15(b) LSC	05/05/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	05/05/2015	ID Prefix F0428 Reg. # 483.60(c) LSC	05/05/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KS/kfd	Date: 05/29/2015	Signature of Surveyor: 03048	Date: 05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/26/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245407	A. Building B. Wing **01 - MAIN BUILDING 01**	5/29/2015

Name of Facility	Street Address, City, State, Zip Code
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/10/2015**	ID Prefix	Correction Completed **04/13/2015**	ID Prefix	Correction Completed **04/15/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **04/10/2015**	ID Prefix	Correction Completed **05/26/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0071		Reg. # **NFPA 101** LSC K0144		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/29/2015	35482	05/29/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/25/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TQG1

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Facility ID: 00045

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(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 004/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
11/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 9, 2015

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

RE: Project Number S5407023

Dear Mr. Jensen:

On March 26, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
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 May 5, 2015, 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 May 5, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 June 26, 2015 (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 September 26, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to allow 1 of 24 residents (R61) interviewed regarding choices related to their sleeping and waking preferences. Findings include: R61 was admitted to the facility on 10/14/14. The quarterly Minimum Data Assessment (MDS) dated 1/18/15, indicated R61 had diagnoses that included: Parkinson's disease, seizure disorder, depression and dementia. The MDS also	F 242	St. John Lutheran Home will continue to ensure that all residents including #61 have the right to make choices about aspects of his or her life in the facility that are significant to the resident. The Interdisciplinary Care Plan Team and the nursing staff will be re-inserviced concerning resident rights to make choices. The IDCPT will assess choice preferences of residents prior to the initial care conference and at least quarterly	5/5/15

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

Electronically Signed | 04/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 identified R61 as having moderately impaired cognition. During interview with R61 on 3/23/15, at 6:59 p.m. he was asked what time he usually would get up in the morning. R61 stated staff usually got him up around 6:00 a.m. R61 further stated that when he was living at home he would usually get up around 8:00 a.m. R61 stated, "They get me up when they want to." The resident verified that when staff got him up that early he was just tired right away in the morning and wanted to lay in his recliner During observation of morning cares on 3/25/15, at 7:13 a.m. R61 was observed to be dressed and seated in his wheelchair by the dining room table in the 2 Southwest (SW) dining area. R61 was awakened by staff at 7:18 a.m. to eat his breakfast. On 03/25/15, at 9:48 a.m. nursing assistant (NA)-A was interviewed and stated R61 was usually assisted out of bed between 6:00 and 6:30 a.m. In addition, NA-A stated R61 had been assisted out of bed around 6:00 a.m. that morning. On 03/26/15, at 7:18 a.m. R61 was observed dressed and seated in his wheelchair in the 2 SW dining area. R61 was observed to have his head down and appeared to be sleeping. On 03/26/15, at 7:21 a.m. NA-B stated R61 had been assisted out of bed at 6:15 a.m. that morning. NA-B stated when she'd asked R61 whether he was ready to get up he'd stated," Oh, I suppose". NA-B stated sometimes R61 would let staff know when he wanted to get up otherwise	F 242	thereafter. Documentation of choice preferences will be made on the plan of care and on the resident assignment sheet. Resident #61 has been reassessed for choices and documented on is plan of care and assignment sheet. Social Services will monitor by interviewing residents about compliance with choices within the first month after admission and at least quarterly thereafter at the care conferences. Results of interviews will be reported to the facility QA & A committee.	

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F 242	Continued From page 2 he was gotten up around 6:00-6:30 a.m. On 3/26/15, at 9:15 a.m. R61's wife was interviewed by telephone. R61's wife verified R61 would usually get up around "8:30 or so at home". She further stated it really didn't make sense for her husband to be gotten up at 6:00 a.m. stating, "I doubt he is awake then. I know they have to give him his first medication at 7:00 a.m. because that is when it is scheduled. I am not sure why they can't wait until later." During interview with the social worker (SW)-A on 3/26/15, at 9:35 a.m. SW-A stated she was unsure but thought staff asked residents about their preferences regarding their routines for going to bed and getting up during the admission process. SW-A stated residents should be able to sleep in and verified they could receive breakfast later. SW-A also stated schedules should meet the individual resident's needs. During review of R61's medical record, a Resident-Data Collection form was located. The form was dated 10/14/14, date of admission. The form had a section for sleeping preference which identified R61 had indicated his preference to get up after 7:30 a.m. During interview with registered nurse (RN)-B on 3/26/15 at 10:30 a.m., RN-B stated she'd thought the family had requested R61 be assisted out of bed earlier. However then stated she was not sure why staff had assisted R61 out of bed at 6:00 a.m.	F 242		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		5/5/15

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F 329	Continued From page 3 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring for potential side effects of antipsychotic medications was conducted for 1 of 5 residents (R56) reviewed for unnecessary medications. The findings include: R56 was observed on 3/24/15, at 4:07 p.m. walking slowly and unsteadily. The resident	F 329	St. John Lutheran Home will continue to ensure that each resident's drug regime, including resident #56, is free of unnecessary drugs. Monitoring of side effects of antipsychotic drugs will include documentation of orthostatic blood pressure monitoring or documentation of resident's refusal to allow. Licensed Nursing staff and the Interdisciplinary Care Plan Team will be re-inserviced on all aspects of F-329 including monitoring	

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F 329	Continued From page 4 appeared to hug the edges of doors and walls for support. R56 was observed to wander into a dining room and was observed to reappear at 4:11 p.m. R56 continued to wander down a hallway in a slow and unsteady manner until he walked into a linen hamper parked in the hall. He was observed to slowly edge sideways around the linen hamper and once clear, he resumed forward movement, hugging the wall again as he moved in a slow shuffle, his head down, his shoulders stooped. R56's record was reviewed and the face sheet indicated the resident had diagnoses including dementia with behavioral disturbances, difficulty in walking, and unspecified psychosis. In addition, the progress notes indicated R56 had experienced falls on 2/7/15 and on 11/7/14. Current physician orders included an order for an antipsychotic medication Risperdal 0.5 milligrams (mg) twice daily for management of the unspecified psychosis. A physician's order dated 2/7/14 directed staff to monitor R56's orthostatic blood pressures monthly due to the antipsychotic medication use. The Plan of Care dated 10/8/13, identified a problem for R56 "... Behavior ...[related to] dementia with behavior disturbances, psychosis." Interventions included, "Medicate with Risperdal...per MD (medical doctor) order and monitor for side effects." Monthly drug reviews for R56, conducted by the consulting pharmacist, were reviewed from April 2014 to March 26, 2015. No irregularities had been noted since April of 2014. Review of R56's medication administration	F 329	of blood pressure changes when on anti-psychotics. Resident #56 has had orthostatic blood monitoring initiated. The Interdisciplinary Care Plan Team will continue to review each resident's medication regime at quarterly care conferences. The Pharmacy consultant will continue to review each resident's medication regime monthly. To monitor compliance, the Director of Nursing will audit 8 resident's medication regimes, including some on anti-psychotic medications for the next 3 months or as directed by the QA & A committee. Audit results will be reported to the QA & A committee.	

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F 329	Continued From page 5 records (MARs) from October 2014 through February 2015 failed to include documentation of orthostatic blood pressure monitoring monthly. During an interview on 3/26/15, at 10:22 a.m. the nurse manager for 1st floor stated during review of the MARs, "I do not see any orthostatic blood pressures in here." She added, "I would expect staff to document if they tried to obtain an orthostatic blood pressure, even if R56 was uncooperative or refused, and I don't see that." On 3/26/15, at 1:31 p.m. an interview was conducted with the director of nursing (DON). The DON stated she would expect staff monitoring of residents utilizing antipsychotic medications which would include checking orthostatic blood pressures at least monthly. She also stated that when orthostatic blood pressures were ordered by the physician, they should have been completed as ordered.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		5/5/15

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F 428	Continued From page 6 Based on observation, interview and document review the facility failed to ensure the pharmacist identified irregularities related to the facility's failure to conduct monitoring for potential side effects of antipsychotic medications for 1 of 5 residents (R56) reviewed for unnecessary medications. The findings include: Monthly drug reviews for R56, conducted by the consulting pharmacist, were reviewed from April 2014 to March 26, 2015. No irregularities had been noted since April of 2014. R56 was observed on 3/24/15, at 4:07 p.m. walking slowly and unsteadily. The resident appeared to hug the edges of doors and walls for support. R56 was observed to wander into a dining room and was observed to reappear at 4:11 p.m. R56 continued to wander down a hallway in a slow and unsteady manner until he walked into a linen hamper parked in the hall. He was observed to slowly edge sideways around the linen hamper and once clear, he resumed forward movement, hugging the wall again as he moved in a slow shuffle, his head down, his shoulders stooped. R56's record was reviewed and the face sheet indicated the resident had diagnoses including dementia with behavioral disturbances, difficulty in walking, and unspecified psychosis. In addition, the progress notes indicated R56 had experienced falls on 2/7/15 and on 11/7/14. Current physician orders included an order for an antipsychotic medication Risperdal 0.5 milligrams (mg) twice daily for management of the unspecified psychosis. A physician's order dated	F 428	St. John Lutheran Home will continue to ensure that each resident's medication regime, including resident #56, is reviewed at least once per month by a licensed Pharmacist and any irregularities reported to the attending physician and Director of Nursing. The requirements for monitoring of antipsychotic meds was discussed with the Pharmacy Consultant and recommendations will include orthostatic blood pressure monitoring in the future. The Interdisciplinary Care Plan Team will continue to monitor each resident's medication regime on a quarterly basis at care conferences. The Director of Nursing will monitor by reviewing the monthly Pharmacy consultant report and any recommendations on a monthly basis.	

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F 428	Continued From page 7	F 428		

2/7/14 directed staff to monitor R56's orthostatic blood pressures monthly due to the antipsychotic medication use.

The Plan of Care dated 10/8/13, identified a problem for R56 "... Behavior ...[related to] dementia with behavior disturbances, psychosis." Interventions included, "Medicate with Risperdal...per MD (medical doctor) order and monitor for side effects."

Review of R56's medication administration records (MARs) from October 2014 through February 2015 failed to include documentation of orthostatic blood pressure monitoring monthly.

During an interview on 3/26/15, at 10:22 a.m. the nurse manager for 1st floor stated during review of the MARs, "I do not see any orthostatic blood pressures in here." She added, "I would expect staff to document if they tried to obtain an orthostatic blood pressure, even if R56 was uncooperative or refused, and I don't see that."

On 3/26/15, at 1:31 p.m. an interview was conducted with the director of nursing (DON). The DON stated she would expect staff monitoring of residents utilizing antipsychotic medications which would include checking orthostatic blood pressures at least monthly. She also stated that when orthostatic blood pressures were ordered by the physician, they should have been completed as ordered and that the interdisciplinary team should be reviewing resident medications and side effects routinely, but at least on a quarterly basis.

Despite attempts to reach the consultant pharmacist by telephone, the consultant

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F 428	Continued From page 8 pharmacist was not able to be reached for an interview regarding his monitoring of the facility's failure to monitor for potential side effects of R56's antipsychotic medication use.	F 428		

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. John Lutheran Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/17/2015

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

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

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K 000	Continued From page 2 Rooms. The facility has a capacity of 85 beds and had a census of 72 at time of the survey. St Johns Lutheran Home has elected to use the following categorical waivers - Extinguishing Requirements, Capacity of Means of Egress, Doors, Clean Waste & Patient Record Recycling Containers and Combustible decorations on walls, doors and ceilings. Because all of the construction types & heights for an existing health care occupancy met the minimum requirements at NFPA 101 (2000) Table 19.1.6.2, the facility's construction type was downgraded to Type V(111) construction, and surveyed as one building. One Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and	K 011	The hardware on the 2 hour fire separation door that separates the nursing home from the memory care center has been replaced so the door	4/10/15

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K 011	Continued From page 3 8.2.3.2. The deficient practice could affect all 72 residents. Findings include: On facility tour between 08:30 AM and 2:30 PM on 03/25/2015, observation revealed, that the 2nd floor - 2 hour fire separation door from Nursing Home to Memory Care Center does not positively latch. This deficient practice was confirmed by the Facility Maintenance Director (BW) at the time of discovery.	K 011	positively latches. Ongoing compliance will be monitored by the Plant Operations Director	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 30 out of 72 residents.	K 029	The doors to the lower paint room and the clean utility room have been equipped with a self closing device. Ongoing compliance will be monitored by the Plant Operations Director	4/13/15

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K 029	Continued From page 4 Findings include: On facility tour between 08:30 AM and 2:30 PM on 03/25/2015, observation revealed that the following was found: 1. The door to lower paint room (over 50 sq. ft.) does not have a self-closing device. 2. The door to clean utility - (over 50 sq. ft.) does not have a self-closing device. These deficient practices were confirmed by the Facility Maintenance Director (BW) at the time of discovery.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was confirmed the facility failed to sufficiently vary the times of the fire drills. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2,	K 050	The Life Safety Code regulations regarding scheduling fire drills at unexpected times and under varying conditions have been reviewed by the Staff Development Coordinator and the	4/15/15

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/25/2015**

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

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K 050	Continued From page 5 and CMS policy. In a fire emergency, this deficient practice could affect all 72 patients, staff and visitors. FINDINGS INCLUDE: On facility tour between 08:30 AM and 2:30 PM on 03/25/2015, while reviewing fire drill reports for calendar year 2015/2014, it was confirmed that not all fire drills had been sufficiently varied. Specifically, fire drills conducted on the Day-shift during the 1st and 2nd quarter and on the Afternoon shift during the 3rd and 4th quarter were commenced not greater than twenty-six (26) minutes apart. This deficient practice was confirmed by the Facility Maintenance Director (BW) at the time of discovery.	K 050	Plant Operations Director. Ongoing compliance will be monitored by the Administrator and Staff Development Coordinator.	
K 071 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash	K 071		4/10/15

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K 071	Continued From page 6 collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the laundry chute in accordance with the following requirements of 2000 NFPA 101, Section 19.5.4. The deficient practice could affect 30 out of 72 residents. Findings include: On facility tour between 08:30 AM and 2:30 PM on 03/25/2015, observation revealed that the laundry chute door located in the Soiled Utility Room on 1 South did not have a positive latching device on the chute door. This deficient practice was confirmed by the Facility Maintenance Director (BW) at the time of discovery.	K 071	The laundry chute door has had a positive latching device installed to ensure it positively latches. Ongoing compliance will be monitored by the plant operations director.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		5/26/15

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K 144	Continued From page 7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 72 residents. Findings include: On facility tour between 08:30 AM and 2:30 PM on 03/25/2015, documentation review of the monthly inspection logs of 2015/2014 for the diesel emergency generator revealed that the transfer time and the cool down time was not being documented. This deficient practice was confirmed by the Facility Maintenance Director (BW) at the time of discovery	K 144	The NFPA regulations regarding monthly inspection of the emergency generator have been reviewed with the maintenance department. The maintenance log for the generator will be updated to include: Transfer time, Load time, and cool down time. Ongoing compliance will be monitored by the Plant Operations Director.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
April 9, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5407023

Dear Mr. Jensen:

The above facility was surveyed on March 23, 2015 through March 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 immediately contact Kathryn Serie 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	03/26/2015

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/23/15-3/26/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to read the results of a tuberculin skin test (TST) within the required timeframe per Center for Disease Control (CDC) and facility policy, for 2 of 5 nursing assistants (NA-B and NA-C) reviewed for tuberculosis (TB) screening.	21426	corrected	5/5/15

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21426	Continued From page 3 Findings include: Review of nursing assistant (NA)-B employee file indicated a hire date of 2/16/15. The first step TST was administered on 1/20/15 at 4:00 p.m. and read on 1/22/15 at 6:25 p.m. The second step TST was administered on 2/17/15 at 9:30 a.m. and read on 2/20/15 p.m. (77 hours and 20 minutes after administration). Review of nursing assistant (NA)-C employee file indicated a hire date of 2/2/15. The first step TST was administered on 2/2/15 at 10:15 a.m. and read on 2/6/15 at 10:00 a.m. (95 hours and 45 minutes after administration). When interviewed on 3/26/15, at 11:11 a.m. the director of nursing (DON) confirmed that the TST administered on 1/20/15 for NA-B and the TST administered on 2/2/15 for NA-C were each read at greater than 72 hours after administration. The policy/procedure titled, Employee Tuberculosis Protocol revised 10/2009, included: "Employees must have the Mantoux test read by a nurse 48 to 72 hours after the test is administered." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could reeducate nursing staff to their policies for resident and employee Tuberculosis screening, and could perform audits to ensure their policies were being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21530	Continued From page 4	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		5/5/15

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21530	Continued From page 5 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the pharmacist identified irregularities related to the facility's failure to conduct monitoring for potential side effects of antipsychotic medications for 1 of 5 residents (R56) reviewed for unnecessary medications. The findings include: Monthly drug reviews for R56, conducted by the consulting pharmacist, were reviewed from April 2014 to March 26, 2015. No irregularities had been noted since April of 2014. R56 was observed on 3/24/15, at 4:07 p.m. walking slowly and unsteadily. The resident appeared to hug the edges of doors and walls for support. R56 was observed to wander into a dining room and was observed to reappear at 4:11 p.m. R56 continued to wander down a hallway in a slow and unsteady manner until he walked into a linen hamper parked in the hall. He was observed to slowly edge sideways around the linen hamper and once clear, he resumed forward movement, hugging the wall again as he moved in a slow shuffle, his head down, his shoulders stooped. R56's record was reviewed and the face sheet indicated the resident had diagnoses including dementia with behavioral disturbances, difficulty in walking, and unspecified psychosis. In addition, the progress notes indicated R56 had experienced falls on 2/7/15 and on 11/7/14.	21530	corrected	

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21530	Continued From page 6 Current physician orders included an order for an antipsychotic medication Risperdal 0.5 milligrams (mg) twice daily for management of the unspecified psychosis. A physician's order dated 2/7/14 directed staff to monitor R56's orthostatic blood pressures monthly due to the antipsychotic medication use. The Plan of Care dated 10/8/13, identified a problem for R56 "... Behavior ...[related to] dementia with behavior disturbances, psychosis." Interventions included, "Medicate with Risperdal...per MD (medical doctor) order and monitor for side effects." Review of R56's medication administration records (MARs) from October 2014 through February 2015 failed to include documentation of orthostatic blood pressure monitoring monthly. During an interview on 3/26/15, at 10:22 a.m. the nurse manager for 1st floor stated during review of the MARs, "I do not see any orthostatic blood pressures in here." She added, "I would expect staff to document if they tried to obtain an orthostatic blood pressure, even if R56 was uncooperative or refused, and I don't see that." On 3/26/15, at 1:31 p.m. an interview was conducted with the director of nursing (DON). The DON stated she would expect staff monitoring of residents utilizing antipsychotic medications which would include checking orthostatic blood pressures at least monthly. She also stated that when orthostatic blood pressures were ordered by the physician, they should have been completed as ordered and that the interdisciplinary team should be reviewing resident medications and side effects routinely, but at least on a quarterly basis.	21530		

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21530	Continued From page 7 Despite attempts to reach the consultant pharmacist by telephone, the consultant pharmacist was not able to be reached for an interview regarding his monitoring of the facility's failure to monitor for potential side effects of R56's antipsychotic medication use. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for	21540		5/5/15

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21540	Continued From page 8 the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring for potential side effects of antipsychotic medications was conducted for 1 of 5 residents (R56) reviewed for unnecessary medications. The findings include: R56 was observed on 3/24/15, at 4:07 p.m. walking slowly and unsteadily. The resident appeared to hug the edges of doors and walls for support. R56 was observed to wander into a dining room and was observed to reappear at 4:11 p.m. R56 continued to wander down a hallway in a slow and unsteady manner until he walked into a linen hamper parked in the hall. He was observed to slowly edge sideways around the linen hamper and once clear, he resumed forward movement, hugging the wall again as he moved in a slow shuffle, his head down, his shoulders stooped. R56's record was reviewed and the face sheet indicated the resident had diagnoses including dementia with behavioral disturbances, difficulty in walking, and unspecified psychosis. In addition, the progress notes indicated R56 had experienced falls on 2/7/15 and on 11/7/14.	21540	corrected	

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	00045	A. BUILDING: _____ B. WING _____	03/26/2015

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21540	Continued From page 9 Current physician orders included an order for an antipsychotic medication Risperdal 0.5 milligrams (mg) twice daily for management of the unspecified psychosis. A physician's order dated 2/7/14 directed staff to monitor R56's orthostatic blood pressures monthly due to the antipsychotic medication use. The Plan of Care dated 10/8/13, identified a problem for R56 "... Behavior ...[related to] dementia with behavior disturbances, psychosis." Interventions included, "Medicate with Risperdal...per MD (medical doctor) order and monitor for side effects." Monthly drug reviews for R56, conducted by the consulting pharmacist, were reviewed from April 2014 to March 26, 2015. No irregularities had been noted since April of 2014. Review of R56's medication administration records (MARs) from October 2014 through February 2015 failed to include documentation of orthostatic blood pressure monitoring monthly. During an interview on 3/26/15, at 10:22 a.m. the nurse manager for 1st floor stated during review of the MARs, "I do not see any orthostatic blood pressures in here." She added, "I would expect staff to document if they tried to obtain an orthostatic blood pressure, even if R56 was uncooperative or refused, and I don't see that." On 3/26/15, at 1:31 p.m. an interview was conducted with the director of nursing (DON). The DON stated she would expect staff monitoring of residents utilizing antipsychotic medications which would include checking orthostatic blood pressures at least monthly. She also stated that when orthostatic blood pressures	21540		

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21540	Continued From page 10 were ordered by the physician, they should have been completed as ordered. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications are reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation is in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21540		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify	21830		5/5/15

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21830	Continued From page 11 either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the	21830		

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21830	Continued From page 12 patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to allow 1 of 24 residents (R61) interviewed regarding choices related to their sleeping and waking preferences. Findings include: R61 was admitted to the facility on 10/14/14. The quarterly Minimum Data Assessment (MDS)	21830	corrected	

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21830	Continued From page 13 dated 1/18/15, indicated R61 had diagnoses that included: Parkinson's disease, seizure disorder, depression and dementia. The MDS also identified R61 as having moderately impaired cognition. During interview with R61 on 3/23/15, at 6:59 p.m. he was asked what time he usually would get up in the morning. R61 stated staff usually got him up around 6:00 a.m. R61 further stated that when he was living at home he would usually get up around 8:00 a.m. R61 stated, "They get me up when they want to." The resident verified that when staff got him up that early he was just tired right away in the morning and wanted to lay in his recliner During observation of morning cares on 3/25/15, at 7:13 a.m. R61 was observed to be dressed and seated in his wheelchair by the dining room table in the 2 Southwest (SW) dining area. R61 was awakened by staff at 7:18 a.m. to eat his breakfast. On 03/25/15, at 9:48 a.m. nursing assistant (NA)-A was interviewed and stated R61 was usually assisted out of bed between 6:00 and 6:30 a.m. In addition, NA-A stated R61 had been assisted out of bed around 6:00 a.m. that morning. On 03/26/15, at 7:18 a.m. R61 was observed dressed and seated in his wheelchair in the 2 SW dining area. R61 was observed to have his head down and appeared to be sleeping. On 03/26/15, at 7:21 a.m. NA-B stated R61 had been assisted out of bed at 6:15 a.m. that morning. NA-B stated when she'd asked R61 whether he was ready to get up he'd stated," Oh,	21830		

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21830	Continued From page 14 I suppose". NA-B stated sometimes R61 would let staff know when he wanted to get up otherwise he was gotten up around 6:00-6:30 a.m. On 3/26/15, at 9:15 a.m. R61's wife was interviewed by telephone. R61's wife verified R61 would usually get up around "8:30 or so at home". She further stated it really didn't make sense for her husband to be gotten up at 6:00 a.m. stating, "I doubt he is awake then. I know they have to give him his first medication at 7:00 a.m. because that is when it is scheduled. I am not sure why they can't wait until later." During interview with the social worker (SW)-A on 3/26/15, at 9:35 a.m. SW-A stated she was unsure but thought staff asked residents about their preferences regarding their routines for going to bed and getting up during the admission process. SW-A stated residents should be able to sleep in and verified they could receive breakfast later. SW-A also stated schedules should meet the individual resident's needs. During review of R61's medical record, a Resident-Data Collection form was located. The form was dated 10/14/14, date of admission. The form had a section for sleeping preference which identified R61 had indicated his preference to get up after 7:30 a.m. During interview with registered nurse (RN)-B on 3/26/15 at 10:30 a.m., RN-B stated she'd thought the family had requested R61 be assisted out of bed earlier. However also added she was not sure why staff had assisted R61 out of bed at 6:00 a.m. SUGGESTED METHOD OF CORRECTION:	21830		

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21830	Continued From page 15 The DON or designee could re-educate staff to offer/document choices related to waking/bed times and bathing preferences. This information could be reviewed at care conference meetings. The designee could perform audits to ensure compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		