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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WWJQ

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 **03/05/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (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
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria King, Unit Supervisor 03/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/07/2013 (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
Posted 4/12/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/08/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5407

On March 4, 2013, a Post Certification Revisit (PCR) by review of the plan of correction was completed by the Department of Health and on March 5, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the January 18, 2013 standard survey, effective February 27, 2013. Refer to the CMS-2567b for both health and life safety code.

Effective February 27, 2013, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5407

April 7, 2013

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 February 27, 2013 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 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,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 12, 2013

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

RE: Project Number S5407021

Dear Mr. Jensen:

On January 24, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 18, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 5, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 18, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 18, 2013, effective February 27, 2013 and therefore remedies outlined in our letter to you dated January 24, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5407r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245407	A. Building B. Wing	3/4/2013

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**02/27/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**02/27/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**02/27/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**02/27/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/MK	03/12/2013	08769	03/04/2013
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
1/18/2013			

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**	3/5/2013

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 Reg. # **NFPA 101** LSC K0011	**02/27/2013**	ID Prefix Reg. # **NFPA 101** LSC K0061	**02/27/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	03/12/2013	22373	03/05/2013
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
1/16/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WWJQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245407**

2.STATE VENDOR OR MEDICAID NO.
(L2) **346740600**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 IMR**	**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 **105** (L18)

13.Total Certified Beds **105** (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	IMR
	105			
(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):

At the time of the January 18, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NEII 02/15/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/01/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/8/2013 ML

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

Certified Mail # 7011 2000 0002 5148 8434

January 24, 2013

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

RE: Project Number S5407021

Dear Mr. Jensen:

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

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

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

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

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

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

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

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

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:

Maria King
Minnesota Department of Health
Division of Compliance Monitoring
Licensing and Certification Program
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789

Telephone: (507) 344-2716
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 27, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 27, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 18, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 18, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

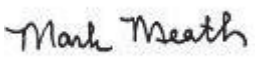
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Licensing and Certification File 5407s13.rtf

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 _____	01/18/2013

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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident's plan of care was implemented as written for 3 of 5 residents (R114, R47 and R105) reviewed in the sample, who was dependent on staff for activities of daily living. Findings include: R114 who was dependent upon staff for assistance with hygiene/grooming was observed to have jagged and dirty fingernails. R114 resided in the facility's memory care unit. During observations on 1/14/13 at 1:29 p.m., and	F 282	Please see attached Plan of Correction RECEIVED FEB 04 2013 Minnesota Dept of Health Mankato Accept my 2/15/13	2-27-13

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

Chief Executive Officer 2-1-13

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
	245407	A. BUILDING _____ B. WING _____	01/18/2013

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F 282	Continued From page 1 1/17/13 at 2:45 p.m., R114's fingernails were observed to be jagged and dirty. Review of the facility's bath schedule identified that R114 had received a bath on Friday 1/11/13. R114's record was reviewed. An MDS dated 11/5/12, indicated R114 required extensive assistance of 1 staff for personal hygiene needs, and that the resident had severe cognitive loss. The care plan identified that R114 required assistance with activities of daily living (ADL's) related to (R/T) cognitive deficits, dementia, osteoarthritis, balance problems, and inattention. Care plan interventions for R114 included: extensive assistance of 1 staff with whirlpool tub bath weekly, and extensive assistance of 1 staff for grooming needs. During interview with NA-E on 1/17/13 at 2:45 p.m., NA-E verified that R114 was completely dependent upon staff for fingernail care. NA-E stated the resident should have received nail care assistance on his bath day. NA-E then observed R114's fingernails with the surveyor and verified they were dirty and jagged. NA-E also verified that residents were supposed to receive assistance with washing their hands and face every morning and at bedtime, which would include observation of their fingernails. During interview with registered nurse (RN)-C on 1/17/13 at 2:59 p.m., RN-C verified that R114 had jagged and dirty fingernails. R47's fingernails had not been trimmed or cleaned by staff in accordance with the resident's	F 282		

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F 282	Continued From page 2 current plan of care. R47 was observed to have long, jagged and soiled fingernails on 1/15, 1/16 and 1/17/13. R47's record was reviewed. The resident's current plan of care, indicated R47 required staff assistance with activities of daily living (ADL's) related to legal blindness and weakness. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene, and staff to trim the resident's fingernails as needed (PRN). During interview with trained medication aide (TMA)-B at 11:45 a.m. on Wednesday 1/16/13, TMA-B stated the nursing assistants were supposed to trim the residents' fingernails on their bath days. TMA-B said that R47's bath day was Tuesday (the day prior). TMA-B confirmed R47 had received a bath, but verified it appeared he had not gotten his nails trimmed. During interview with licensed practical nurse (LPN)-A at 12:23 p.m. on 1/16/13, she stated that although she was R47's primary day nurse, she had been unawared the resident had not had his nails trimmed as expected on his bath day. During interview with NA-A at 4:00 p.m. on 1/17/13, NA-A stated R47's fingernails should have been trimmed and cleaned on his bath day this week. At the time of the interview, NA-A observed the resident's nails and confirmed they were long and dirty. R105's fingernails had not been trimmed or cleaned as identified in the plan of care.	F 282		

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F 282	Continued From page 3 R105 was observed to have long, soiled fingernails on 1/15, 1/16 and 1/17/13. R105's record was reviewed. The current plan of care indentifed R105 as having an alteration in self care related to generalized weakness, low back discomfort, decline in mobility, arthritic changes and minimal range of motion in his shoulders. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene. During interview with NA-C at 3:00 p.m on 1/17/13, she stated the nursing assistants were supposed to trim R105's fingernails on bath day. NA-C confirmed that R105 had received a bath on Friday 1/11/13, but that the resident's nails were still long and dirty. The facility's policy, Resident Cares dated 7/2005, included directions for staff: "Residents will be provided with cares on each shift. Individual needs are addressed on resident care plan & assignment sheet...Cares will consist of partial bathing including hands, face, back, under breasts, peri/rectac areas, hair care, shaving..."	F 282		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	Please see attached Plan of Correction RECEIVED FEB 04 2013 Minnesota Dept of Health Mankato	2-27-13

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F 312	Continued From page 4 by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 4 of 5 residents in the sample (R30, R114, R47 and R105) who were dependent upon staff for nail care. Findings include: R30 was observed to have jagged and dirty fingernails throughout the survey. R30 resided in the locked memory care unit. During observation on 1/14/13 at 1:32 p.m., R30 was observed to have jagged and dirty fingernails. Review of the bath schedule indicated that R30 had just received a bath on Friday 1/11/13 on the evening shift. R30's record was reviewed. A minimum data set (MDS) dated 10/8/12, indicated R30 required extensive assist of 2 staff for personal hygiene care and had severely impaired decision making. The care plan dated January 2013, included the following problem statement: Requires assistance with activities of daily living (ADL's) related to (R/T) end-stage dementia, history (hx) of bilateral fracture (fx) of pubis, poor mobilities and recent right (rt) femur fx. Interventions included: Extensive physical assist of 1-2 staff with personal hygiene. During interview with nursing assistant (NA)-D on 1/18/13 at 9:34 a.m., she stated that R30 was completely dependent upon staff for fingernail care which was routinely provided on bath day by	F 312		

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F 312	Continued From page 5 the nursing assistants. NA-D then observed the resident's fingernails with the surveyor and verified they were dirty and jagged. NA-D further verified that every morning and bedtime residents were supposed to have their hands and face washed by staff, which would include observing the condition of the fingernails. R114 who was dependent upon staff for assistance with hygiene/grooming was observed to have jagged and dirty fingernails. R114 resided in the facility's memory care unit. During observations on 1/14/13 at 1:29 p.m., and 1/17/13 at 2:45 p.m., R114's fingernails were observed to be jagged and dirty. Review of the facility's bath schedule identified that R114 had received a bath on Friday 1/11/13. R114's record was reviewed. An MDS dated 11/5/12, indicated R114 required extensive assistance of 1 staff for personal hygiene needs, and that the resident had severe cognitive loss. The care plan identified that R114 required assistance with activities of daily living (ADL's) related to (R/T) cognitive deficits, dementia, osteoarthritis, balance problems, and inattention. Care plan interventions for R114 included: extensive assistance of 1 staff with whirlpool tub bath weekly, and extensive assistance of 1 staff for grooming needs. During interview with NA-E on 1/17/13 at 2:45 p.m., NA-E verified that R114 was completely dependent upon staff for fingernail care. NA-E stated the resident should have received nail care	F 312		

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F 312	Continued From page 6 assistance on his bath day. NA-E then observed R114's fingernails with the surveyor and verified they were dirty and jagged. NA-E also verified that residents were supposed to receive assistance with washing their hands and face every morning and at bedtime, which would include observation of their fingernails. During interview with registered nurse (RN)-C on 1/17/13 at 2:59 p.m., RN-C verified that R114 had jagged and dirty fingernails and were in need of cleaning. R47 was observed to have long, jagged and soiled fingernails on 1/15, 1/16 and 1/17/13. R47's record was reviewed. The resident's current plan of care, indicated R47 required staff assistance with activities of daily living (ADL's) related to legal blindness and weakness. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene, and staff to trim the resident's fingernails as needed (PRN). During interview with trained medication aide (TMA)-B at 11:45 a.m. on Wednesday 1/16/13, TMA-B stated the nursing assistants were supposed to trim the residents' fingernails on their bath days. TMA-B said that R47's bath day was Tuesday (the day prior). TMA-B confirmed R47 had received a bath, but verified it appeared he had not gotten his nails trimmed. During interview with licensed practical nurse (LPN)-A at 12:23 p.m. on 1/16/13, she stated that although she was R47's primary day nurse, she had been unawared the resident had not had his nails trimmed as expected on his bath day.	F 312		

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F 312	Continued From page 7 During interview with NA-A at 4:00 p.m. on 1/17/13, NA-A stated R47's fingernails should have been trimmed and cleaned on his bath day this week (Tuesday 1/15/13). At the time of the interview, NA-A observed the resident's nails and confirmed they were long and dirty. R105 was observed to have long, soiled fingernails on 1/15, 1/16 and 1/17/13. R105's record was reviewed. The current plan of care indentifed R105 as having an alteration in self care related to generalized weakness, low back discomfort, decline in mobility, arthritic changes and minimal range of motion in his shoulders. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene. During interview with NA-C at 3:00 p.m on 1/17/13, she stated the nursing assistants were supposed to trim R105's fingernails on bath day. NA-C confirmed that R105 had received a bath on Friday 1/11/13, but that the resident's nails were still long and dirty. The facility's policy, Resident Cares dated 7/2005, included directions for staff: "Residents will be provided with cares on each shift. Individual needs are addressed on resident care plan & assignment sheet...Cares will consist of partial bathing including hands, face, back, under breasts, peri/rectac areas, hair care, shaving..."	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	Please see attached Plan of Correction	2-27-13

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F 315	Continued From page 8 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and determine an adequate toileting program for 1 of 3 residents (R105) who was reviewed for a decline in urinary incontinence. Findings include: R105 had a decline in his urinary continence and facility staff had not re-assessed him for a new toileting program, to maintain or improve his continence. During observations of R105 at 3:33 p.m. on 1/17/13, nursing assistant (NA)-C was observed to assist the resident to the toilet. The resident's incontinent pad was observed to be wet with a moderate amount of urine. During the observation, NA-C stated that the resident is toileted every two hours and is occasionally incontinent of bladder. She also said that the resident would use the call light at times to get assistance to be toileted. Review of the nursing assistant care sheets, confirmed the resident was to be toileted by staff every two hours and as	F 315		

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F 315	Continued From page 9 needed. R105's record was reviewed. The resident had been admitted to the facility on 8/2/12 with diagnoses including: dementia, muscle weakness, dysphasia, benign prostatic hypertrophy (BPH) and history of falls. An admission minimum data set (MDS) dated 8/9/12, identified R105 as having occasional incontinence of bladder with no toileting program. The quarterly MDS dated 11/5/12, identified the resident as being frequently incontinent of bladder with no toileting program. The care plan updated 11/12/12, identified R105 as having an alteration in elimination of bowel and bladder related to BPH, dependence with toileting needs, dribbling of urine, and dementia. Interventions included: requires physical assistance of staff with toileting, staff to manage incontinent products, resident will call for assistance as needed with toileting and staff to observe for any unusual changes with continence. A bladder assessment for R105 dated 8/7/12, indicated the resident was continent of bladder, with risk factors identified as impaired mobility and dependence on staff for transfers. Under the topic of Summary and Program Placement Decision on the form, was a section for Treatment Program. A check mark had been marked in front of "scheduled toileting/habit training." However, there was no specific frequency of toileting identified for implementation. At the bottom of the assessment form was an area titled "Reviews". A date of 11/5/12 was entered and the reason for review	F 315		

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F 315	Continued From page 10 indicated "1st qtr (quarter)" and in the next box it was checked yes for "able to participate in bladder program." There was no indication the resident's decline in continence had been evaluated. During interview with registered nurse (RN)- B, at 8:00 a.m. on 1/16/13, RN-B stated she was R105's primary night nurse. RN-B stated the night staff toileted the resident every 2 hours however, he was usually incontinent at those times. During interview with RN-A at 5:00 p.m. on 1/17/13, RN-A confirmed R105 had experienced a decline in his urinary incontinence. RN-A further stated the resident had not been re-assessed to dermine an individualized toileting program, to improve or maintain his urinary continence. During interview with the director of nursing (DON) at 7:30 p.m. 1/17/13, the DON confirmed a re-assessment of R105's toileting needs should have been conducted on 11/5/12, when the resident's decline in urinary continence was first identified.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	Please see attached Plan of Correction RECEIVED FEB 0 4 2013 Minnesota Dept of Health Mankato	2-27-13

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F 329	Continued From page 11 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 interview and document review the facility failed to monitor for the efficacy of a psychoactive medication for 1 of 10 residents (R114) reviewed for unnecessary medications. Findings include: R114 routinely utilized a psychoactive medication that was not monitored adequately to determine efficacy for the need of this medication. A minimum data set (MDS) dated 11/5/12, identified R114 as having severe cognitive loss and the trouble concentrating. R114's record was reviewed. The resident had been admitted to the memory care unit of the facility on 10/29/12, with diagnoses including: dementia with recent aggressive behaviors; memory loss; depression around the time of his	F 329		

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F 329	Continued From page 12 wife's death (about 4 years ago). The admission physician orders indicated R114 received an antidepressant, Celexa 10 mg (milligrams), daily for depression There was no documentation of mood or behavior monitoring found in R114's record. Licensed practical nurse (LPN)- B was interviewed on 1/18/13 at 8:35 a.m. LPN-B stated the resident had not exhibited any mood or behavior issues so there was no mood and/or behavior monitoring documented. When asked how she knew R114 didn't exhibit any behaviors if there was no documentation. LPN-B had no reply. During additional interview with LPN-B on 1/18/13 at 8:45 a.m., verified that no target behaviors had been identified and no monitoring was being documented related to mood and/or behaviors to determine the efficacy of the antidepressant medication Celexa. On 1/17/13 at 2:40 p.m. registered nurse (RN)-C verified there was no documentation in the book used to track resident behaviors/moods related to R114's use of an antidepressant medication.	F 329		

F282 SS=D 483.20(k)(3)(ii) Services by qualified persons/per care plan

St. John Lutheran Home disagrees with the findings of non-compliance and the deficiency cited. We believe we do provide services by qualified persons in accordance with each residents written plan of care, including residents 114, 47, and 105.

- **Regarding cited residents**
  The fingernails of residents 114, 47, and 105 have been trimmed and cleaned.

- **How will the facility identify other residents having potential to be affected by the same deficient practice?**
  All residents who are dependent on staff for ADL assistance are at risk

- **Measures put in place or systemic changes made to ensure deficient practice does not occur.**
  All nursing staff will be re-inserviced on implementing the plan of care as written and what to do if the resident is uncooperative. The charge nurses on each shift will be re-educated to ensure that the plan of care is implanted as written for all residents.

- **How will the facility monitor?**
  The charge nurses, station supervisors, and the Director of Nursing will perform rounds to ensure the plan of care is implemented as written and resident refusals documented and alternatives documented

- **Who is responsible to maintain compliance?**
  The charge nurses, station supervisors, and the Director of Nursing

- **Completion date for certification purposes only… 2-27-13**

F312 SS=E 483.25(a)(3) ADL care provided for dependent residents

St. John Lutheran Home disagrees with the findings of non-compliance and the deficiency cited. We believe we do provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, including residents 30, 114, 47, and 105.

- **Regarding Cited Residents:**
  Residents 30, 114, 47, and 105 have had their nails trimmed and cleaned

- **How will the facility identify other residents having potential to be affected by the same deficient practice?**
  All residents who are dependent on staff for ADL assistance are at risk

- **Measures put in place or systemic changes made to ensure deficient practice does not occur.**
  All nursing staff will be inserviced on proper grooming including nail care.

- **How will the facility monitor?**
  The charge nurses on each shift will do focused rounds on each shift for 3 three weeks, and will continue to monitor during their regular shifts after the initial focus. The charge nurses will document resident refusals and follow action will be taken. The Director of Nursing and station supervisors will make random rounds to ensure grooming is complete.

- **Who is responsible to maintain compliance?**
  The charge nurses, station supervisors, and the Director of Nursing

- **Completion date for certification purposes only… 2-27-13**

F315 SS=D 483.25(d) No catheter, prevent UTI, restore bladder

St. John Lutheran Home disagrees with the findings of non-compliance and the deficiency cited. We have and will continue to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as possible, including resident 105

- **Regarding Cited Residents:**
  Resident 105 bladder incontinency has been re-assessed and the plan of care has been updated as necessary

- **How will the facility identify other residents having potential to be affected by the same deficient practice?**
  Comparisons have made to the last 6 months of MDS's to any changes in bladder incontinence. Residents identified will have bladder function reassessment and their plan of care updated as necessary.

- **Measures put in place or systemic changes made to ensure deficient practice does not occur.**
  Nurses who complete the MDS have been re-educated on the need to reassess whenever a change occurs in bladder function from one MDS to the next or from the last annual MDS, or when changes in incontinentcy patterns have been identified. All nursing staff will be inserviced to report changes in incontinence patterns so residents can be reassessed timely and the plan of care updated.

- **How will the facility monitor?**
  The Director of Nursing or designee will audit comparisons of new MDS completed each week to the last MDS to help identify any changes in incontinence and perform an audit of the medical record to ensure a reassessment has been completed.

- **Who is responsible to maintain compliance?**
  The Director of Nursing and Station supervisors are responsible to maintain compliance.

- **Completion date for certification purposes only... 2-27-13**

F329 SS=D 483.25(l) Drug regimen is free from unnecessary drugs

St. John Lutheran Home disagrees with the findings of non-compliance and the deficiency cited. We believe we have and will continue to 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 received gradual dose reductions and behavioral interventions, unless clinically contraindictated in an effort to discontinue these drugs, including resident 114

- **Regarding cited residents:**
  Resident 114 med regime will be reviewed by the attending physician during next scheduled rounds.

- **How will the facility identify other residents having potential to be affected by the same deficient practice?**
  All residents are potentially at risk

- **Measures put in place or systemic changes made to ensure deficient practice does not occur.**
  All licensed nurses and the Interdisiplinary team will be re-inserviced on the need to monitor the effectiveness of all psycho-active drugs on an ongoing basis. Mood monitoring will continue to be done on Care Tracker and a summary will be printed monthly and placed in the medical record for each resident using anti-depressants including resident 114. All nursing staff and interdisciplinary team will be re-inserviced on the use of Care Tracker data on mood state and behavior as well as individualized behavior tracking sheets and interdisciplinary progress notes.

- **How will the facility monitor?**
  The pharmacy consultant will continue to monitor the efficiency of all resident medications regimes during monthly reviews. The charge nurse and attending physician will continue to review each resident's regimes during regular visits, and follow up on the pharmacist recommendations. The Interdisciplinary team will continue to review the residents medication regime at quarterly care conferences.

- **Who is responsible to maintain compliance?**
  The Pharmacy consultant and the Interdisciplinary team are responsible for compliance.

- **Completion date for certification purposes only… 2-27-13**

Respectfully Submitted

Joshua Jensen
Chief Executive Officer
St. John Lutheran Home

Date: February 1, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/16/2013

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
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, on January 16, 2013. 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	RECEIVED FEB - 4 2013 POC ok TS 2-5-13	

DC: 02.27.2013

EXIT: 01.18.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Chief executive officer	1-31-13

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
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K 000	Continued From page 2 Rooms. The facility has a capacity of 105 beds and had a census of 89 at time of the survey. 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=D	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: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - 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:	K 011	**K011** The penetration in the 2-hour fire wall located in between the nursing home and assisted living will be sealed with a listed fire rated intumescent caulk. Ongoing compliance will be monitored by the Plant Operations Director by randomly checking concealed spaces for possible penetrations.	2-27-13

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	245407	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/16/2013

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K 011	Continued From page 3 Based on observation, the facility failed to properly maintain a required 2-hour fire separation in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of 20 of 105 residents, staff and visitors. FINDINGS INCLUDE: On 1/16/13 at 10:55 AM, observation revealed building wiring penetrating the 2-hour fire wall separating the nursing home from an assisted living facility. This penetration was located in the concealed space above the lay-in ceiling, directly above the fire door leading from the nursing home to the assisted living facility, and the interstitial space surrounding the wiring/cabling was not properly sealed with a listed fire-rated intumescent caulk or other approved method. This finding was verified with the facility building engineer at the time of discovery.	K 011		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: NFPA 101 [2000] LIFE SAFETY CODE SURVEY STANDARD - Required automatic sprinkler systems have valves supervised so that at least a	K 061	**K061** The supply valve will be fitted with an electronic monitoring switch. Other valves will be inspected by the plant operations director to ensure that they are in compliance.	2-27-13

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K 061	Continued From page 4 local alarm will sound when the valves are closed, in accordance with NFPA 101 [2000] Chapter 19, Section 19.3.5 and Chapter 9, Section 9.7.2 and NFPA 72 [1999]. Based upon observation, not all components of the facility's automatic fire sprinkler system were equipped with required supervisory attachments. In a fire emergency, this deficient practice could adversely affect 105 of 105 residents, staff and visitors. FINDINGS INCLUDE: On 1/16/13 at 1:10 PM, observation revealed one (1) outside stem and yoke (OS&Y) valve located in the basement Storage Room, which controlled the main water supply for the building fire sprinkler system. Although this supply valve was chained and locked in the open position, it was not equipped with an electrically interconnected supervisory attachment, such as a tamper switch. This existing arrangement was not in accordance with the requirements at NFPA 101 [2000] Sections 9.7.2.1 and 9.7.2.2 and NFPA 72 [1999]. This finding was confirmed with the chief building engineer.	K 061		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8434

January 24, 2013

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 S5407021

Dear Mr. Jensen:

The above facility was surveyed on January 14, 2013 through January 18, 2013 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Mankato Place 12 Civic Center Plaza Suite #2105 Mankato Minnesota 56001. 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 Maria King at (507) 344-2716.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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 _____	01/18/2013

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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: On January 14, 15, 16, 17 and 18th, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	RECEIVED FEB 2 6 2013 Minnesota Dept of Health Mankato Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 2-21-13

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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: On January 14, 15, 16, 17 and 18th, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	2 000	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 which 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident's	2 565		

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2 565	Continued From page 2 plan of care was implemented as written for 3 of 5 residents (R114, R47 and R105) reviewed in the sample, who was dependent on staff for activities of daily living. Findings include: R114 who was dependent upon staff for assistance with hygiene/grooming was observed to have jagged and dirty fingernails. R114 resided in the facility's memory care unit. During observations on 1/14/13 at 1:29 p.m., and 1/17/13 at 2:45 p.m., R114's fingernails were observed to be jagged and dirty. Review of the facility's bath schedule identified that R114 had received a bath on Friday 1/11/13. R114's record was reviewed. An MDS dated 11/5/12, indicated R114 required extensive assistance of 1 staff for personal hygiene needs, and that the resident had severe cognitive loss. The care plan identified that R114 required assistance with activities of daily living (ADL's) related to (R/T) cognitive deficits, dementia, osteoarthritis, balance problems, and inattention. Care plan interventions for R114 included: extensive assistance of 1 staff with whirlpool tub bath weekly, and extensive assistance of 1 staff for grooming needs. During interview with NA-E on 1/17/13 at 2:45 p.m., NA-E verified that R114 was completely dependent upon staff for fingernail care. NA-E stated the resident should have received nail care assistance on his bath day. NA-E then observed R114's fingernails with the surveyor and verified they were dirty and jagged. NA-E also verified	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 3 that residents were supposed to receive assistance with washing their hands and face every morning and at bedtime, which would include observation of their fingernails. During interview with registered nurse (RN)-C on 1/17/13 at 2:59 p.m., RN-C verified that R114 had jagged and dirty fingernails. R47's fingernails had not been trimmed or cleaned by staff in accordance with the resident's current plan of care. R47 was observed to have long, jagged and soiled fingernails on 1/15, 1/16 and 1/17/13. R47's record was reviewed. The resident's current plan of care, indicated R47 required staff assistance with activities of daily living (ADL's) related to legal blindness and weakness. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene, and staff to trim the resident's fingernails as needed (PRN). During interview with trained medication aide (TMA)-B at 11:45 a.m. on Wednesday 1/16/13, TMA-B stated the nursing assistants were supposed to trim the residents' fingernails on their bath days. TMA-B said that R47's bath day was Tuesday (the day prior). TMA-B confirmed R47 had received a bath, but verified it appeared he had not gotten his nails trimmed. During interview with licensed practical nurse (LPN)-A at 12:23 p.m. on 1/16/13, she stated that although she was R47's primary day nurse, she had been unawared the resident had not had his nails trimmed as expected on his bath day.	2 565		

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2 565	Continued From page 4 During interview with NA-A at 4:00 p.m. on 1/17/13, NA-A stated R47's fingernails should have been trimmed and cleaned on his bath day this week. At the time of the interview, NA-A observed the resident's nails and confirmed they were long and dirty. R105's fingernails had not been trimmed or cleaned as identified in the plan of care. R105 was observed to have long, soiled fingernails on 1/15, 1/16 and 1/17/13. R105's record was reviewed. The current plan of care indentifed R105 as having an alteration in self care related to generalized weakness, low back discomfort, decline in mobility, arthritic changes and minimal range of motion in his shoulders. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene. During interview with NA-C at 3:00 p.m on 1/17/13, she stated the nursing assistants were supposed to trim R105's fingernails on bath day. NA-C confirmed that R105 had received a bath on Friday 1/11/13, but that the resident's nails were still long and dirty. The facility's policy, Resident Cares dated 7/2005, included directions for staff: "Residents will be provided with cares on each shift. Individual needs are addressed on resident care plan & assignment sheet...Cares will consist of partial bathing including hands, face, back, under breasts, peri/rectac areas, hair care, shaving..." SUGGESTED METHOD OF CORRECTION: The administrator with the director of nursing or designee could review and revise resident care	2 565		

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(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) COMPLETE DATE
2 565	Continued From page 5 plans to ensure that residents receive assistance with grooming according to their assessed needs. They could educate the staff and develop a monitoring system to assure that the residents grooming needs are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene care for 4 of 5 residents in the sample (R30, R114, R47 and R105) who were dependent upon staff for nail care. Findings include: R30 was observed to have jagged and dirty fingernails throughout the survey.	2 830		

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	00045	A. BUILDING _____ B. WING _____	01/18/2013

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2 830	Continued From page 6 R30 resided in the locked memory care unit. During observation on 1/14/13 at 1:32 p.m., R30 was observed to have jagged and dirty fingernails. Review of the bath schedule indicated that R30 had just received a bath on Friday 1/11/13 on the evening shift. R30's record was reviewed. A minimum data set (MDS) dated 10/8/12, indicated R30 required extensive assist of 2 staff for personal hygiene care and had severely impaired decision making. The care plan dated January 2013, included the following problem statement: Requires assistance with activities of daily living (ADL's) related to (R/T) end-stage dementia, history (hx) of bilateral fracture (fx) of pubis, poor mobilities and recent right (rt) femur fx. Interventions included: Extensive physical assist of 1-2 staff with personal hygiene. During interview with nursing assistant (NA)-D on 1/18/13 at 9:34 a.m., she stated that R30 was completely dependent upon staff for fingernail care which was routinely provided on bath day by the nursing assistants. NA-D then observed the resident's fingernails with the surveyor and verified they were dirty and jagged. NA-D further verified that every morning and bedtime residents were supposed to have their hands and face washed by staff, which would include observing the condition of the fingernails. R114 who was dependent upon staff for assistance with hygiene/grooming was observed to have jagged and dirty fingernails. R114 resided in the facility's memory care unit. During observations on 1/14/13 at 1:29 p.m., and	2 830		

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2 830	Continued From page 7 1/17/13 at 2:45 p.m., R114's fingernails were observed to be jagged and dirty. Review of the facility's bath schedule identified that R114 had received a bath on Friday 1/11/13. R114's record was reviewed. An MDS dated 11/5/12, indicated R114 required extensive assistance of 1 staff for personal hygiene needs, and that the resident had severe cognitive loss. The care plan identified that R114 required assistance with activities of daily living (ADL's) related to (R/T) cognitive deficits, dementia, osteoarthritis, balance problems, and inattention. Care plan interventions for R114 included: extensive assistance of 1 staff with whirlpool tub bath weekly, and extensive assistance of 1 staff for grooming needs. During interview with NA-E on 1/17/13 at 2:45 p.m., NA-E verified that R114 was completely dependent upon staff for fingernail care. NA-E stated the resident should have received nail care assistance on his bath day. NA-E then observed R114's fingernails with the surveyor and verified they were dirty and jagged. NA-E also verified that residents were supposed to receive assistance with washing their hands and face every morning and at bedtime, which would include observation of their fingernails. During interview with registered nurse (RN)-C on 1/17/13 at 2:59 p.m., RN-C verified that R114 had jagged and dirty fingernails and were in need of cleaning. R47 was observed to have long, jagged and soiled fingernails on 1/15, 1/16 and 1/17/13.	2 830		

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2 830	Continued From page 8 R47's record was reviewed. The resident's current plan of care, indicated R47 required staff assistance with activities of daily living (ADL's) related to legal blindness and weakness. Interventions included: the resident requires extensive physical assistance of staff with personal hygiene, and staff to trim the resident's fingernails as needed (PRN). During interview with trained medication aide (TMA)-B at 11:45 a.m. on Wednesday 1/16/13, TMA-B stated the nursing assistants were supposed to trim the residents' fingernails on their bath days. TMA-B said that R47's bath day was Tuesday (the day prior). TMA-B confirmed R47 had received a bath, but verified it appeared he had not gotten his nails trimmed. During interview with licensed practical nurse (LPN)-A at 12:23 p.m. on 1/16/13, she stated that although she was R47's primary day nurse, she had been unawared the resident had not had his nails trimmed as expected on his bath day. During interview with NA-A at 4:00 p.m. on 1/17/13, NA-A stated R47's fingernails should have been trimmed and cleaned on his bath day this week (Tuesday 1/15/13). At the time of the interview, NA-A observed the resident's nails and confirmed they were long and dirty. R105 was observed to have long, soiled fingernails on 1/15, 1/16 and 1/17/13. R105's record was reviewed. The current plan of care indentifed R105 as having an alteration in self care related to generalized weakness, low back discomfort, decline in mobility, arthritic changes and minimal range of motion in his shoulders. Interventions included: the resident	2 830		

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2 830	Continued From page 9 requires extensive physical assistance of staff with personal hygiene. During interview with NA-C at 3:00 p.m on 1/17/13, she stated the nursing assistants were supposed to trim R105's fingernails on bath day. NA-C confirmed that R105 had received a bath on Friday 1/11/13, but that the resident's nails were still long and dirty. The facility's policy, Resident Cares dated 7/2005, included directions for staff: "Residents will be provided with cares on each shift. Individual needs are addressed on resident care plan & assignment sheet...Cares will consist of partial bathing including hands, face, back, under breasts, peri/rectac areas, hair care, shaving..." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could ensure that staff are educated as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The Director of Nursing could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home	2 910		

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2 910	Continued From page 10 without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and determine an adequate toileting program for 1 of 3 residents (R105) who was reviewed for a decline in urinary incontinence. Findings include: R105 had a decline in his urinary continence and facility staff had not re-assessed him for a new toileting program, to maintain or improve his continence. During observations of R105 at 3:33 p.m. on 1/17/13, nursing assistant (NA)-C was observed to assist the resident to the toilet. The resident's incontinent pad was observed to be wet with a moderate amount of urine. During the observation, NA-C stated that the resident is toileted every two hours and is occasionally incontinent of bladder. She also said that the resident would use the call light at times to get assistance to be toileted. Review of the nursing assistant care sheets, confirmed the resident was to be toileted by staff every two hours and as needed.	2 910		

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2 910	Continued From page 11 R105's record was reviewed. The resident had been admitted to the facility on 8/2/12 with diagnoses including: dementia, muscle weakness, dysphasia, benign prostatic hypertrophy (BPH) and history of falls. An admission minimum data set (MDS) dated 8/9/12, identified R105 as having occasional incontinence of bladder with no toileting program. The quarterly MDS dated 11/5/12, identified the resident as being frequently incontinent of bladder with no toileting program. The care plan updated 11/12/12, identified R105 as having an alteration in elimination of bowel and bladder related to BPH, dependence with toileting needs, dribbling of urine, and dementia. Interventions included: requires physical assistance of staff with toileting, staff to manage incontinent products, resident will call for assistance as needed with toileting and staff to observe for any unusual changes with continence. A bladder assessment for R105 dated 8/7/12, indicated the resident was continent of bladder, with risk factors identified as impaired mobility and dependence on staff for transfers. Under the topic of Summary and Program Placement Decision on the form, was a section for Treatment Program. A check mark had been marked in front of "scheduled toileting/habit training." However, there was no specific frequency of toileting identified for implementation. At the bottom of the assessment form was an area titled "Reviews". A date of 11/5/12 was entered and the reason for review indicated "1st qtr (quarter)" and in the next box it was checked yes for "able to participate in bladder program." There was no indication the resident's decline in continence had been	2 910		

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2 910	Continued From page 12 evaluated. During interview with registered nurse (RN)- B, at 8:00 a.m. on 1/16/13, RN-B stated she was R105's primary night nurse. RN-B stated the night staff toileted the resident every 2 hours however, he was usually incontinent at those times. During interview with RN-A at 5:00 p.m. on 1/17/13, RN-A confirmed R105 had experienced a decline in his urinary incontinence. RN-A further stated the resident had not been re-assessed to dermine an individualized toileting program, to improve or maintain his urinary continence. During interview with the director of nursing (DON) at 7:30 p.m. 1/17/13, the DON confirmed a re-assessment of R105's toileting needs should have been conducted on 11/5/12, when the resident's decline in urinary continence was first identified. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are comprehensively assessed for incontinence in order to determine appropriate interventions for care. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 910		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An	21535		

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21535	Continued From page 13 unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor for the efficacy of a psychoactive medication for 1 of 10 residents (R114) reviewed for unnecessary medications. Findings include: R114 routinely utilized a psychoactive medication that was not monitored adequately to determine efficacy for the need of this medication. A minimum data set (MDS) dated 11/5/12, identified R114 as having severe cognitive loss and the trouble concentrating.	21535		

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21535	Continued From page 14 R114's record was reviewed. The resident had been admitted to the memory care unit of the facility on 10/29/12, with diagnoses including: dementia with recent aggressive behaviors; memory loss; depression around the time of his wife's death (about 4 years ago). The admission physician orders indicated R114 received an antidepressant, Celexa 10 mg (milligrams), daily for depression There was no documentation of mood or behavior monitoring found in R114's record. Licensed practical nurse (LPN)- B was interviewed on 1/18/13 at 8:35 a.m. LPN-B stated the resident had not exhibited any mood or behavior issues so there was no mood and/or behavior monitoring documented. When asked how she knew R114 didn't exhibit any behaviors if there was no documentation. LPN-B had no reply. During additional interview with LPN-B on 1/18/13 at 8:45 a.m., verified that no target behaviors had been identified and no monitoring was being documented related to mood and/or behaviors to determine the efficacy of the antidepressant medication Celexa. On 1/17/13 at 2:40 p.m. registered nurse (RN)-C verified there was no documentation in the book used to track resident behaviors/moods related to R114's use of an antidepressant medication. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with State and Federal regulatory requirements.	21535		

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21535	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		