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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZDD7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00227

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245272**

2.STATE VENDOR OR MEDICAID NO.
(L2) **180482000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARTIN LUTHER CARE CENTER**
(L4) **1401 EAST 100TH STREET**
(L5) **BLOOMINGTON, MN** (L6) **55425**

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 **05/04/2017** (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)
12/31

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

12.Total Facility Beds **137** (L18)

13.Total Certified Beds **137** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	137			
(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 :
Mary Heim, HFE NE II 06/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 08/01/2017 (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
02/01/1985
(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
05/01/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245272

June 13, 2017

Ms. Claire Purdie, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Dear Ms. Purdie:

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 April 15, 2017 the above facility is certified or recommended for:

137 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 137 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 13, 2017

Ms. Claire Purdie, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: Project Number S5272026

Dear Ms. Purdie:

On March 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 2, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2017, effective April 15, 2017 and therefore remedies outlined in our letter to you dated March 22, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZDD7

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(L3) **MARTIN LUTHER CARE CENTER**
(L4) **1401 EAST 100TH STREET**
(L5) **BLOOMINGTON, MN** (L6) **55425**

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) **01/01/2007**

6. DATE OF SURVEY **03/02/2017** (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)
12/31

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	137			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Dawn Chiabotti, HFE NEII 04/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/27/2017 (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
02/01/1985
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 22, 2017

Ms. Jody Barney, Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, Minnesota 55425

RE: Project Number S5272026

Dear Ms. Barney:

A standard survey was completed at your facility on March 2, 2017, by the Minnesota Department of Health and on March 6, 2017, by the Minnesota Department of 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Saint Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 15, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 2, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

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

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 166		4/15/17

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

Electronically Signed | 03/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 166	Continued From page 1	F 166		

address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 166	Continued From page 2 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure efforts were made by the facility to resolve family concerns for 1 of 1 resident (R197) who reported unresolved concerns. Findings include: R197's family member (FM-A) reported concerns regarding R197's care at the facility on 2/27/17, at 3:50 p.m. FM-A explained R197 needed to use the toilet every two hours or sooner, or she self-transferred and had experienced falls in the bathroom. Staff did not also ensure R197's call light was within reach. In addition, R197 had an	F 166	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 166	Continued From page 3 undesirable weight gain of 50 pounds in the last year. FM-A explained when visiting R197 around noon three times weekly, he found the resident alone in the bathroom. At mealtime, FM-A expressed concern hot chocolate was served prior to the meal and stated, "That stuff has so much sugar in it." In addition, desserts were also served prior to the meal. FM-A stated, "I'm afraid when I'm not here she will fall trying to go to the bathroom." FM-A stated he attended R197's care conferences and had brought up these concerns at the last four care conferences, but "nothing gets done." FM-A explained R197 ate slowly, so had requested staff take her to the toilet at 1:30 p.m. and then return her to the table so she was able to finish eating. R197 was assisted to the dining room by FM-A on 2/27/17, at 4:59 p.m. FM-A visited a while and then left. Following dinner at 6:13 p.m. R197 was assisted out of the dining room and to the television area. Four minutes later R197 was observed propelling herself down the hallway to her room, opened the bathroom door, went inside the bathroom and shut the door. At 6:19 p.m. the call light in the adjacent room was activated and answered by licensed practical nurse (LPN)-B, who walked past R197's room without looking into the room to answer the other resident's call light. While LPN-B was assisting the resident next door, R197 emerged from the bathroom and wheeled herself in front of her television. At 6:26 p.m. LPN-B noticed R197 was in her room and asked if she needed to use the toilet to which R197 responded, "I already did." LPN-B asked, "Next time can you ask someone first? Don't do it by yourself," and then left the room. R197 was interviewed on 2/27/17, at 6:31 p.m.	F 166	the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this time frame should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents' findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. Facility held care conference for Resident 197 and family to discuss concerns. Care plan reviewed and updated. Facility reviewed grievance log to ensure no outstanding/unresolved complaints. Social Services to bring Formal Grievance/Concern Form to care conferences if families wish to fill out formal grievance for Administrator to address. Social Services also	

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F 166	Continued From page 4 and reported she was able to take herself to the toilet, and denied needing staffs' assistance. R197 also denied experiencing falls, and said she knew where to find her call light and how to use it. At the time of the interview the call light was observed clipped onto the middle of the bedspread. R197 was observed continuously on 3/1/17, from 7:11 to 9:51 a.m. R197 was in her wheelchair and in the dining room waiting for breakfast at 7:11 a.m. At 7:18 a.m. nursing assistant (NA)-C verified he was assigned to care for R197, and said he had assisted her out of bed at around 6:45 a.m. NA-C stated R197 needed help with activities of daily living. When toileted that morning, NA-C said R197 was able to stand, hold onto the grab bars and urinate in the toilet." NA-C stated R197 wheeled herself to her room after breakfast and put on her call light if she needed to use the toilet. At 7:24 a.m. R197 was wheeled out of the dining room to her room by registered nurse (RN)-A, her medications were administered in her room, and then she was assisted back to the dining room 7:27 a.m. At 7:53 a.m. the dietary staff began setting up breakfast and provided R197 with hot chocolate, orange juice and water. At 8:06 a.m. dietary aide (DA)-A took R197's order of scrambled eggs, wheat toast and applesauce. DA-A stated R197 was usually provided full portion sizes, but sometimes was given half portion sized, depending on the meal. At 8:37 a.m. R197 wheeled to the window, looked out, and then wheeled back to the table to resume eating. At 9:07 a.m. a therapeutic recreation staff entered the dining room to assist R197 to exercise activity. When asked if she was still eating, R197 nodded "yes." At 9:22 a.m. RN-A asked R197 is she was still eating and she	F 166	documenting concerns in facility grievance log. Grievance Policies were reviewed. Re-education provided with the IDT team members on handling grievances and complaints. Audit complaint/grievance log for 3 months to ensure appropriate follow up is completed in a timely manner. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. Administrator is responsible for compliance.	

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replied "yes." At 9:34 a.m. dietary came to clean the dining room and asked R197 is she was done eating she said, "yes." R197 consumed 100% of her food, but continued drinking her hot chocolate. R197 was then assisted back to her room at 9:41 a.m. by RN-A. RN-A verified he had not asked nor had he taken R197 to the toilet, and explained "She will let us know when she has to use the bathroom." RN-A turned on the television for R197 and informed her, "Let us know if you have to go to the bathroom. Don't do it yourself. Call for help," and then left the room. At 9:51 a.m. RN-A entered R197's room and asked if she had to use the bathroom, she replied, "yes." RN-A then assisted R197 to use the toilet, more than three hours after she had been assisted with morning cares at approximately 6:45 a.m.

In a follow-up interview on 3/1/17, at 9:57 a.m. NA-C verified R197's toileting schedule was every two hours. NA-C explained R197 was able to let staff know "85% of the time" when she needed to use the toilet. When it was brought to NA-C's attention it had been greater than two hours since R197 had been offered the toilet, NA-C said he had asked her when she was eating breakfast. When the surveyor reported having continuous observations of R197 at breakfast, NA-C reported being too busy with other residents that morning and he had in fact not offered R197 toileting, but should have done so.

During an interview on 3/1/17, at 10:09 a.m. RN-B explained she expected staff to follow the resident's individualized care plan, and if they were to be toileted every two hours, then staff "should be doing it." RN-B verified R197's FM-A had expressed concerns he would like R197

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toileted right away following meals as he was concerned she would self-transfer and fall. RN-B was not sure why toileting had not been provided according to R197's care plan.

The director of nutrition and culinary (DNC) was interviewed on 3/1/17, at 10:52 a.m. The DNC reported she attended R197's care conferences and verified FM-A had voiced concern regarding R197's weight gain and being served hot chocolate at meals. The DNC explained R197's weight was now stable at 138, and due to her age, she did not wish to restrict her desire for hot chocolate or to lessen her meal portions. The DNC verified they had not tried to offer hot chocolate with fewer calories/sugar, but would try the following day.

Licensed social worker (LSW)-B stated on 3/2/17, at 8:51 a.m. he attended quarterly care conferences for R197 and was responsible for filling out the care conference forms in resident medical records. LSW-B stated the only concern noted for R197 was ensuring she was assisted to the toilet to minimize the risk for self-transferring and falls. LSW-B stated, "I watch [R197] while she is in the dining room. When I see her going down to her room to go to the bathroom, I will get an aide. I know she self-transfers to the bathroom."

In a follow-up interview on 3/2/17, at 9:12 a.m. RN-B verified one of FM-A concerns was ensuring R197's call light was within reach. RN-B stated, "We all are aware that [R197] will toilet herself, and I have heard [FM-A] say at one care conference that 'nothing gets done.'"

NA-C verified on 3/2/17, at 9:23 a.m. he was

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aware R197 will self-transferred to the toilet.

R197's annual Minimum Data Set (MDS) dated 12/14/16, indicated the resident had diagnoses including dementia and was severely cognitively impaired, but did not display behavioral symptoms or refuse care. R197 was occasionally incontinent and required extensive assistance of one staff to transfer and use the toilet. The resident had experienced one fall without injury in the previous quarter. R197's admission MDS dated 1/19/15, indicated a height of 59 inches and weight of 101 pounds without evidence of weight loss or gain in the previous six months. R197's MDS's indicated an increase in the resident's weight each subsequent quarter. On 3/30/16, the resident had experienced a weight gain of 5% or greater and it was noted the resident was on a physician-ordered weight gain regimen. The MDS dated 6/22/16, also noted a weight gain, but indicated the resident was not on a physician-ordered weight gain regimen, however, on 12/14/16, the MDS indicated the resident had a continued weight gain at 143 pounds.

R197's care plan dated 2/16/17, also indicated diagnoses of dementia, as well as hemiplegia (paralysis on half the body) due to a stroke and urinary incontinence with urgency (inability to hold urine). R197 required one staff to assist her with toileting. Staff was directed to assist R197 to use the toilet every two hours, to anticipate her needs, instruct R197 to use the call light to ask for help and to wait for staffs' assistance. Additionally the care plan dated 7/27/15, indicated "Resident has been seen hiding her call light in her bed. Call light moved from visible area on bed to between mattresses while staff not in resident room.

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F 166	Continued From page 8 Shorter call light installed to prevent resident from reaching." R197's medical record contained three care conference (CC) summaries dated, 6/30/16, 9/29/xx (no year) and 12/28/16. CC summaries from 6/30/16 and 9/29/xx indicated FM-A attended, however, no reports of family concerns was reported on either summary, and the last fall was identified as occurring on 2/13/16. The CC summary sheet from 12/28/16, revealed FM-A attended, however, no family concerns or suggestions were noted and R197 last experienced a fall on 10/29/16. It was noted, "Toileting herself, staff to assist her after meals to her room and toilet her." A concern/grievance policy was requested, but was not provided.	F 166		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were ensure linens were provided in a manner that promoted dignity for 1 of 1 resident (R13) who had unclean linen. Findings include:	F 241	Resident 13's care plan reviewed. Kardex, nursing assistant assignment sheets, updated to reflect when appropriate to change soiled linen. Reviewed and revised AM Cares Policy and HS Cares Policy.	4/15/17

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F 241	Continued From page 9 R13's two pillow cases were observed soiled on 2/27/17, at 2:35 p.m. The pillow cases had dried red-tinged fluid that appeared to be dried blood. One pillow case had an approximate inch and a half long line of multiple red circle stains. The second pillow case had one small red circle stain with a dried dark red piece of a scab in the middle of the red stain. R13 was observed the following day at 3:31 p.m. lying on her bed with her head resting on the stained pillow cases. On 3/1/17, at 8:23 a.m. R13's room was observed to be very clean, her bed was made, the sheets/bedspread was neat, clean and pulled up to the pillows, was folded back and a bath blanked had been placed in the middle of the made bed. The two pillows were placed neatly on the top of her folded down bed sheets. The pillows were propped up one behind the other, and no stains were showing. However, when the pillow was turned over the same red stains observed on 2/27/17, were still present. R13's care plan dated 5/21/14, indicated the resident required staffs' assistance for activities of daily living (ADL's). It was also noted R13 had the potential for alteration in skin integrity related to cognitive impairment and recurrent itching, and "scratches self to bleeding." Staff interventions were to moisturize dry skin and update the physician/nurse practitioner regarding sores from itchy skin that worsened or did not show improvement. R13's physicians orders dated 3/1/17, indicated the resident had diagnoses including atopic dermatitis and schizophrenia. During an interview on 3/1/17, at 9:47 a.m. nursing assistant (NA)-B stated she was familiar with R13 and had provided cares to her that morning. NA-B said R13 received a bath or	F 241	Re-education was provided to licensed nursing and nursing assistants on reviewed policy which include changing bed linen. Weekly random audits for 3 months on each unit completed to ensure compliance with changing bed linen. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 241	Continued From page 10 shower on Monday and Wednesday mornings. R13 was observed on 3/1/17, at 10:03 a.m. lying on her bed with her head on the clean side of the pillow cases and her arm tucked under the pillow. When R13 was asked if she was aware her pillow cases were not clean she immediately looked at the scabs on her arms and then at her pillows. R13 looked at the underside of the pillows, made a disgusted face and stated, "I would prefer to have clean ones." The same day at 10:09 a.m. both NA-B and registered nurse (RN)-B verified R13's pillow cases were soiled. NA-B stated she had made a mistake earlier, and R13's bath days were Mondays and Thursdays, which was why she had not changed the linens. NA-B further stated, "I was waiting for her to have her bath because I thought she gets it today." Both RN-B and NA-B verified soiled linens should have been changed regardless of a resident's bath day. RN-B verified she was aware R13 had scabs that she picked on her arms that then bled. RN-B stated the spots appeared like dried blood. RN-B and the director of nursing both stated all residents should have been well groomed and been provided with clean linens. The facility's 10/16, AM Cares policy indicated the purpose was to provide cleanliness, comfort, and neatness of residents, and to monitor the resident's condition and promote psychosocial well-being. Staff were instructed to wash each resident's face and straighten and/or change all bed linens as needed.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		4/15/17

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F 246	Continued From page 11 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call light were in reach for 1 of 3 (R161) reviewed for environmental concerns. Findings included: R161's call light was observed out of the resident's reach on 2/27/17 at 4:35 p.m. The call light was attached to R161's sweater on the upper, back side of his arm. Licensed social worker (LSW)-B and registered nurse (RN)-B then confirmed R161 would not have been able to reach the call light. LSW-B then asked R161 if he knew where his call light was and whether he could reach it he answered, "I don't know. It is elsewhere. I can't reach it." R161 extended his arm forward searching for his call light and stated, "I am not sure." RN-B stated, "I do not think the resident would be able to put on his call light because it's not in reach." During a subsequent observation on 3/1/17, at 9:34 a.m. R161 was observed in bed facing the wall with his eyes closed. The call light was attached to the raised grab bar and was hanging	F 246	Resident 13's care plan was reviewed. On March 2, facility completed a site wide audit and completed on-the-spot education with staff in regards to call light placement. Reviewed and revised Call Light Response Policy. Re-education provided to all staff on the Call Light Response Policy. Weekly random audits completed for 3 months to ensure compliance with call light placement. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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down behind the resident.

The following day on 3/2/17, at 11:19 a.m. R161 was seated in a Broda chair and his call light was laying on the bed out of his reach. RN-E verified the call light was on the bed and out of R161's reach. NA-G then stated, "The resident cannot reach the call light. It's too far away from him on the bed."

RN-B then also verified at 11:30 a.m. R161's call light was at least 4-5 feet away from the resident and he could not have reached it. When asked if this posed a problem for the resident RN-B replied, "Yes, not having a call light in reach is a problem. I will find out who is taking care of him and educate the person." LSW-B also stated, "This is not good. We need to educate the staff."

During interview on 3/1/17, at 2:20 p.m. RN-A, she verified R161 would have been able to use his call light "if it is within reach." At 2:25 p.m. NA-I, also verified R161 was capable of using his call light. At 2:25 p.m. RN-B verified the resident was capable of using his call light, but often did not use it. RN-B stated, stated "Resident is able to use the call light, but he usually he does not use it. He might use it during the evening or night but not during the day."

The director of nursing stated on 3/2/17, at 12:00 p.m. "I expect the call light should be in reach of the resident."

R161's 2/20/17, Minimum Data Set assessment revealed the resident had severely cognitive impairment, however, was able to understand and make himself understood. R161 required extensive assistance from staff for cares. R161's

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F 246	Continued From page 13 6/26/17, care plan directed staff to "Ensure that call light is in an easy to reach spot in room." The facility's 2/17, Call Light Response policy revealed, "All call lights will be answered to ensure resident are assisted in a timely manner...Position the call light conveniently for the resident to use. Tell the resident where the call light is."	F 246		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		4/15/17

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F 280	Continued From page 14 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 280		

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F 280	Continued From page 15 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to revise the care plan for 1 of 1 resident (R252) whose transferring needs changed. Findings include: R252's family member (FM)-C reported in an interview on 2/28/17, at 1:46 p.m. that the resident's health care level and condition had not changed since her admission six months prior. R252 was observed on 3/1/17, at 7:49 a.m. while nursing assistant (NA)-A provided personal a.m. cares for the resident. As NA-A requested assistance from NA-H to transfer R252 from the bed to the wheelchair. After placing a transfer belt on the resident, they counted to three and manually lifted the resident to the wheelchair. NA-A explained R252 was legs were weak, and she was totally dependent on staff to lift her during transfers. NA-A stated R252 had not been using her walker "for some time." Later at 10:17 a.m. R252 was again manually lifted to the toilet by two NAs.	F 280	Resident 252's care plan updated to reflect transferring needs. Kardex, our nursing assistant assignment sheet, was updated to reflect the change. Facility wide audit completed to ensure transfer assist for all residents was accurately reflected on the care plan. Reviewed and revised Individualized Care Plan & Care Cards Policy and Change of Condition/Notification Policy. Re-education provided to licensed nursing and nursing assistants on revised Individualized Care Plan & Care Cards Policy and Change of Condition/Notification Policy. Weekly random audits on each unit completed for 3 months to ensure compliance with updating care plans appropriately. A summary of the audits will be reviewed at the Quality Assurance & Performance	

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F 280	Continued From page 16 R252's 9/13/16, admission Minimum Data Set (MDS) revealed diagnoses including a stroke. R252 was assessed as severely cognitively impaired, "not steady" and required extensive assistance from two staff to stand and to move and did not walk. Devices utilized included a wheelchair and walker. In a subsequent MDS dated 12/7/16, R252 continued to require extensive assistance from staff, however, the only device utilized was a wheelchair. R252's 12/7/16, care conference note indicated. "She needs extensive assistance of 1-2 with bed mobility, transfers, dressing, toileting, and personal hygiene." A 12/7/16, Balance/ROM [range of motion] assessment revealed R252 was unsteady when standing and did not walk. Devices checked as used were limited to a wheelchair, and walker was not checked. The 12/24/16, care plan indicated the resident had weakness and required a walker and two staffs' assistance to transfer. A current Visual/Bedside Kardex Report indicated R252 required two staff and a walker for transferring. On 3/1/17, at 8:12 a.m. licensed practical nurse (LPN)-A, reported R252 was supposed to have been transferred with two staff and the aid of a walker. Later at 12:22 p.m. LPN-A verified R252 required more assistance that was reflected on her care plan, and staff were no longer utilizing the walker to aid in transfers. LPN-A explained an assessment would be completed, physical therapy staff would be contacted to determine whether an evaluation was needed related to R252's decline, and the care plan would be updated to reflect the resident's current transfer status.	F 280	Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 280	Continued From page 17 On 3/2/17, at 8:29 a.m. registered nurse (RN)-H who was responsible for completing MDS assessments stated the NAs were responsible for reporting improvement or decline in a resident to the nurse, and the nurse manager was responsible for updating the resident's care plan. RN-H said R252's next MDS was due the following week. On 3/2/17, at 12:18 p.m. the director of nursing (DON) explained the NAs were responsible for reporting any changes in a resident or their ability to the clinical managers or nurses. In addition, an assessment should have been completed, phone calls to notify appropriate people of the change in condition, and changes to the care plan should have been made. The facility's 11/16, Individualized Care Plan policy indicated, "The care plan is updated promptly in response to any change in the resident's condition."	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow the care plan for grooming for 1 of 1 resident (R23) reviewed for	F 282	Resident 23, 13, 197, 44, 281, and 269's care plans were reviewed and revised as appropriate.	4/15/17

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F 282	Continued From page 18 tube feeding, and for 5 of 5 residents (R13, R197, R44, R281, R269) reviewed for activities of daily living (ADLs). Findings include: R23's care plan dated 9/19/16, revealed the resident had a potential alteration in nutrition related to advancing amyotrophic laterals sclerosis (ALS) with hospice care, as well as dysphagia/aspiration pneumonia and G-tube feedings. Staff was instructed staff to "monitor percentage of food intake." The resident could also have a regular diet/pleasure foods such as pudding. Physician orders included Glucerna 1.5 (enteral nutrition for persons with diabetes) at 105 cc's/hour for 12 hours (a total of 1260 cc's), followed by water flushes 225 cc's four times daily. R23 was observed in bed on 2/28/17, at 8:17 a.m. R23's tube feeding was dripping into the trash can next to the resident's bed. Licensed practical nurse (LPN)-C was informed of the observation and stated, "I did not disconnect the feeding tube" and said the resident must have disconnected it herself. LPN-C stated the resident "does that, unfortunately." LPN-C said the staff performed room checks every two hours, and occasionally R23 used her call light to summon help. LPN-C explained R23's tube feeding schedule started at 8:00 p.m. and ended at 8:00 a.m. LPN-C stated, "I did not start the tube feeding--it must be from the night shift." LPN-C confirmed 200 cubic centimeters (cc's) remained in the bag, and then threw the bag with the remaining contents and tubing into the trash can. R23 was again observed on 3/1/17, at 7:13 a.m.	F 282	On the spot training began immediately in order to ensue staff knew how to access the Kardex and view the care plan. Reviewed and revised Individualized Care Plan & Care Cards Policy. Re-education provided to licensed nursing and nursing assistants on the Individualized Care Plan & Care Cards Policy. Weekly random audits completed for 3 months to ensure compliance with following the care plan. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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R23 was crying and her tube feeding was again disconnected from the source. The tube feeding machine was running, and the fluid was dripping onto the floor. There was approximately 500 cc's remaining in the bag. At 7:51 a.m. registered nurse (RN)-G entered to R23's room and explained she was going to give R23 her medication. RN-G then observed the tube feeding dripping on the floor and stated, "Oh the tube feeding machine is on the floor" and verified the fluid was dripping onto the floor. RN-G said 400 cc's remained in the bag and she threw it in the trash can. R23 was again crying, and RN-G stated, "I do not know why she is crying."

RN-F who was present on the night shift was interviewed on 3/1/17 at 7:13 a.m. RN-F stated during the night shift she checked on R23 and provided appropriate monitoring. R23 did not typically use her call light, therefore RN-F stated, "I usually assess her at the beginning of the shift and then every hour. If the resident is sleeping we let her sleep...." RN-F stated the staff alternated checking on R23 every hour between the NAs and nurse. The NAs would then let the nurse know of any problems right away. RN-F explained that at approximately 6:00 a.m. R23's tube feeding was running appropriately, but then the resident tried to go to the other side of the bed and it disconnected. RN-F stated, "I tried to put it back" in, but the resident refused. At 8:23 a.m. RN-F stated, "I probably left the tube on. I forgot to shut it off." When RN-F asked how staff knew how much nutrition and fluid R23 had received RN-F explained the resident should have received 105 cc's per hour. RN-F said that at about 12:30 a.m. there was approximately 500 cc's left in the bag. RN-F then added two additional cans (240 cc's per can) for a "total of

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F 282	Continued From page 20 974 cc's."	F 282		

On 3/1/17, at 8:10 a.m. RN-G took the medication back to the medication cart and stated, "I will give [R23's] medication when she calms down." At 9:21 a.m. RN-G said the night nurse had not reported R23's tube feeding had been disconnected, only that R23 was "screaming and crying at around 6:00 a.m." When asked how staff would know if the resident was receiving adequate nutrition and fluids according to the physician's order, RN-G stated, "I am not sure. I usually look at how much left in the bag and disconnect and throw it away. Maybe she gets 1000 cc's over 12 hours." RN-G explained the evening nurse started the tube feeding and the day shift nurses disconnected it at 8:00 a.m. RN-G then checked R23's physician orders and told the surveyor the resident "gets around 1500 cc's over 12 hours--I threw out 400 cc's in the bag and I will guess there was about 100 cc dripped on the floor, which I already cleaned up."

The registered dietitian (RD) stated on 3/2/17, at 9:13 a.m. regarding R23's tube feeding, "I assume she get her feeding per the order [105 cc's per hour for 12 hours, 1260 cc's per day from 8:00 p.m. to 8:00 a.m.]. Nobody notified me the resident removes the tube feeding--never heard--nobody notified me."

RN-B stated on 3/2/17, at 10:29 a.m. "Yes, the staff reported to me that resident disconnected her G-tube. It doesn't happened often." RN-B said, "It is hard to know the amount dripped on the floor. She did not get the whole amount ordered." RN-B further explained the hospice nurse, dietitian and physician would have been

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updated if the problem was ongoing. RN-B stated, "I don't think this is a pattern for us to let the dietitian know."

The director of nursing stated on 3/2/17, at 12:35 p.m. "They should base how much is left in the bag, but it is hard to know the amount spilled on the floor. It is concerning to me [appropriate staff] was not notified about what is happening."
R13's care plan dated 5/21/14, indicated the resident required physical assistance for ADLs related to cognitive impairment. Staff interventions were to assist the resident with grooming.

R13 was observed on 2/27/17, at 2:35 p.m. and on 2/28/17, at 3:31 p.m. and on 3/1/17, at 9:12 a.m. with multiple long chin hairs.

During an interview on 3/1/17, at 9:47 a.m. nursing assistant (NA)-B stated she was familiar with R13 and provided cares to her that morning. NA-B explained R13 required staff assistance with ADL's at times she can help with her cares and if there are areas where she missed then staff will help do it. NA-B verified she washed R13 face and combed her hair this morning, then NA-B explained R13 will mess her hair up after they combed it as "she likes it that way." NA-B stated R13 was bathed or showered on Mondays and Wednesday mornings.

R13 was observed on 3/1/17, at 10:03 a.m. lying on bed. When R13 was asked if she would prefer to have her chin hair shaved, she felt her chin and said, "Yes." At 10:09 a.m. both NA-B and registered nurse (RN)-B entered R13's room and verified the presence of chin hair. NA-B stated she made a mistake early regarding R13

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bath days. NA-B explained R13's bath days were Mondays and Thursdays not Wednesdays. Both RN-B and NA-B verified grooming should have been provided. The RN-B and the director of nursing both stated residents should have been well groomed.

A request of R13's Body Audit--Bath Forms were requested and only one was provided dated 2/13/16, indicating staff placed a check in the boxes of which services were provided for R13. The "shaved" box had been left un-checked.

R197's care plan dated 2/16/17, indicated diagnoses of dementia, left side hemiplegia (paralysis on half the body) due to a stroke and urinary incontinence with urgency of urination with the need for one staff to assist with toileting. Staff intervention included providing every two hour toileting, "anticipate resident's needs, direct to use call light for assistance and wait for assistance." The care plan dated 7/27/15, indicated "Resident has been seen hiding her call light in her bed. Call light moved from visible area on bed to between mattresses while staff not in resident room. shorter call light installed to prevent resident from reaching."

R197's family member (FM)-A was interviewed on 2/27/17, at 3:50 p.m. FM-A was concerned R197 needed to use the bathroom at least every two hours or sooner, would self-transfer when she had to urinate and had fallen in the bathroom. FM-A reported R197's call light was also not always within her reach.

R197 was observed on 2/27/17, at 4:59 p.m. being wheeled into the dining room by FM-A who stayed for awhile then left. At 6:13 p.m. on

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2/27/17, R197 was taken out of the dining room and brought to the television (tv) room. Four minutes later R197 self propelled herself down the hallway, into her room, open up the bathroom door, when inside and shut it. At 6:19 p.m. the room after R197's call light was activated where licensed practical nurse (LPN)-B walked by R197's room without looking in and answered the activated light next door. While LPN-B was assisting the resident next door, R197 came out of her bathroom and wheeled herself over to her tv to watch a program. At 6:26 p.m. LPN-B left the room next door and noticed R197 in her room, he went into R197 room and asked if she had to use the bathroom, R197 replied "I already did." LPN-B said, "Next time can you ask someone first. Don't do it by yourself."

R197 was observed continuously on 3/1/17, from 7:11 a.m. to 9:51 a.m. R197 was already in her wheel chair, dressed and placed in the dining room for breakfast at 7:11 a.m. At 7:18 a.m. nursing assistant (NA)-C was interviewed inside the dining room. NA-C verified he was taking care of R197 today and stated he got her up around 6:45 a.m. NA-C stated R197 needs help with her ADL's, and said, "went I toileted her this morning she was able to stand, hold onto the grab bars and urinated into the toilet." NA-C stated R197 will wheel herself down to her room after breakfast, put on her call light if she needs to use the bathroom. At 7:24 a.m. R197 was wheeled out of the dining room and brought to her room by registered nurse (RN)-A to be administered medication. RN-A gave the medication and brought R197 back to the dining room at 7:27 a.m. At 7:53 a.m. dietary was present and started to set up breakfast at 8:06 a.m. R197 received her breakfast plate. At 8:37

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F 282	Continued From page 24 a.m. R197 self-propelled self to look out the window then back to the table and continue to eat. At 9:07 a.m. therapeutic recreation came to take resident out for exercise and asked R197 if she was still eating, she nodded her head yes. At 9:22 a.m. RN-A asked R197 is she was still eating , she replied "yes." At 9:34 a.m. dietary came to clean the dining room and asked R197 is she was done eating she said, "yes" and her plate was taken away, but she continued to finish her hot chocolate. At 9:41 a.m. R197 was wheeled back to her room by RN-A. RN-A verified he did not ask R197 if she needed to use the toilet nor did he offer to take her, he explained she will let us know when she has to use the bathroom. RN-A placed R197 in front of her tv, turned on a program and said to R197, "let us know if you have to go to the bathroom, don't do it yourself, call for help then left the room. At 9:51 a.m. RN-A entered R197's room and asked if she had to use the bathroom, she said, "yes" RN-A closed the door and assisted her to the bathroom. A follow-up interview on 3/1/17, at 9:57 a.m. with NA-C A follow-up interview on 3/1/17, at 9:57 a.m. with NA-C verified R197's toileting schedule is every two hours. NA-C explained R197 is able to let staff know 85% of the time when she had to use the bathroom. When it was brought to NA-C attention that it had been over two and half hours since R197 was asked, offered or taken to the bathroom. NA-C said, "I asked [R197] if she had to use the bathroom when she was at breakfast." When it was brought to his attention that a continuous observation was done that morning. NA-C verified he in fact did not ask R197 due to he was busy getting other resident up for the morning and R197 should have been offered toileting.	F 282		

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RN-B explained on 3/1/17, at 10:09 a.m. she expected staff to follow each resident's care plan and if a resident was to be toileted every two hours then staff should be doing it. RN-B verified R197's FM-A voiced his concerns that he would like his mother toileted after every meal right away because he was afraid she will self-toilet and fall. RN-B stated she was unsure why staff did not toilet R197 per her care plan.

R44's current careplan dated 8/13/16, indicated the resident needed assistance from one staff to perform grooming staff. R44's most recent Body Audit--Bath Form dated 2/16/17, indicated the resident had been assisted with shower but was not shaved.

R44 was observed on 2/27/17, at 3:05 p.m., 2/28/17, at 9:49 a.m., 3/1/17, at 8:35 and again at 10:45 a.m. with long facial hair.

R281's 12/6/16, current careplan indicated the resident required staffs' assistance with grooming and bath/shower on Monday evenings. Minimum Data Set (MDS) indicated the resident was severely cognitively severely impaired, but presented no behavioral problems or rejection of cares. R281's corresponding Care Area Assessment (CAA) dated 12/6/16, and current careplan indicated R281 needed staff assistance with grooming and bath/shower on Monday evenings. R281's most recent Body Audit--Bath Form dated 2/27/17, indicated vital signs and weight had been taken but showering and shaving was left blank.

R281 was observed unshaven with a full growth

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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) COMPLETION DATE
F 282	Continued From page 26	F 282		

on his cheeks, chin, and above his mouth 2/27/17, at 4:30 p.m. 2/28/17, at 10:22 a.m. 3/1/17, at 9:34 a.m. and 1:02 p.m. and 3/2/17, at 8:47 a.m. and 12:48 p.m. During the observations the resident was participating in meals and activities with other residents and visitors.

R269's current careplan indicated the resident historically refused bathing, but did take independent sponge baths in her bathroom. The goal was for the resident to be adequately groomed daily. Staff was directed to encourage R269 to bathe or shower on Sunday mornings, and to report refusals to the nurse. Set-up assistance was to be provided for grooming, and assistance provided if the resident did not complete the tasks on her own. R269's 1/25/17, Minimum Data Set (MDS) revealed the resident had moderately impaired cognition with no behavioral problems or rejection of cares. R269 required supervision/oversight with grooming.

R269 was observed on 2/27/17, at 3:00 p.m. with long white chin hairs. R269 stated, "I am concerned about that. I need a tweezers. I have a couple real long ones here." R269 was unsure whether the staff would assist her in removing the unwanted facial hair. The following morning at 9:43 a.m. R269's chin hair was still present while the resident sat with other residents watching television. On 3/1/17, at 8:34 a.m. R269 had long chin hair and her hair appeared greasy and stringy while seated at breakfast with other residents. On 3/2/17, at 8:04 a.m. R269 was again at the dining table and facial hair was still present and her hair again appeared greasy and stringy.

A Body Audit-Bath Form for R269 dated 2/12/17,

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	245272	A. BUILDING _____ B. WING _____	03/02/2017

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F 282	Continued From page 27	F 282		

indicated the resident's weight and vital signs were completed and shower refused. Shaving and washed hair was blank. Bath form dated 1/29/17, indicated R269 allowed weight and vital signs to be completed and declined shower. Shaving and wash hair was left blank.

NA-D stated on 3/1/17, at 9:59 a.m. staff informed residents if they had facial hair, and assisted them to shave every morning and if staff did not have time then, residents would be shaved later in the shift. NA-D explained R269's hair was not washed on the day shift, but "maybe PM's [evening shift]." NA-D stated R269 told staff she did not want to take a shower, and had never showered at the facility. NA-D did not know why R269 resisted showering, but said she was sometimes resistive to cares depending on her mood.

NA-E then stated on 3/1/17, at 10:31 a.m. every time staff observed facial hair on a resident, they were required to assist the resident to shave. NA-E stated had assisted R269 that morning, but the resident had not allowed staff to brush her hair or teeth.

On 3/1/17, at 11:09 a.m. licensed practical nurse (LPN)-G stated NAs were supposed to shave residents "at least" on bath day but "should shave residents daily...It is a dignity thing."

NA-F reported on 3/2/17, at 8:07 a.m. preferring to shave residents when they got up, but it depended on the resident. NA-F explained that if a resident refused care, they re-approached the resident and notified the nurse who would then pass the information on to the evening shift. NA-F stated everyday she had observed R269's chin

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F 282	Continued From page 28 hair but stated the resident "refuses everything," including a shower, clean linen, and bathing because she reported she washed herself. On 3/2/17, at 8:54 a.m. LPN-A stated NAs shaved the resident on shower days and as needed. If a resident refused care they were re-approached and if they continued to refuse, the information was documented and passed on to the next shift. LPN-A stated staff were expected staff to fill out the body audit bath forms indicating which tasks had been completed. LPN-A stated R269 refused showers because she reported she had a shower where she had felt like she was drowning. At 10:32 a.m. LPN-A stated she had talked to R269 and the resident reported she wanted her hair washed at the beauty shop, so she planned to set this up with the beautician. LPN-A stated licensed social worker (LSW)-B planned to contact R269's guardian to request permission and money for the service. LPN-A stated she did not know if this had been completed, as LSW-B had been out ill. LPN-A stated, "I need to talk to [LSW-B] and the business office." The facility's 11/16, Individualized Care Plan policy "...Assures that appropriate focus areas and services are incorporated into the plan, with each discipline contributing to accomplish the goals identified...."	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		4/15/17

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F 309	Continued From page 29 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruises for 1 of 3 residents (R143) reviewed for non-pressure related skin issues. Findings include: R143 was observed on 2/27/17, at 5:19 p.m. with	F 309	Resident 143's care plan was reviewed and revised. Treatment sheet updated to reflect appropriate monitoring. No other resident were identified at that time as having bruises. Reviewed and revised Wound	

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F 309	Continued From page 30 a large purple/yellowish bruise that extended from above the left eye brow down pass the left check bone. When R143 was asked how she sustained the bruising the resident shrugged her shoulders, and then stated, "I believe I fell about six weeks ago." The resident denied anyone abused her. R143's care plan dated 2/21/17, indicated she sustained four in the previous six months and was at risk for accidents/injury related to weakness, history of urinary tract infections (UTIs), decreased muscular coordination due to (d/t) multiple sclerosis and syncope (fainting). R143's care plan lacked interventions directing the staff to monitor bruising for healing or worsening. The medication administration record (MAR) and the treatment administration record (TAR) for R143 for 2/17, lacked any indication R143 required monitoring for healing of the left eye bruise. Skin integrity sheets dated 2/27, 2/28, and 3/1/17, did not reflect the bruise under skin observations and was marked as "none of the above" was observed. R143's progress noted indicated on 2/20/17, had a fall from her wheelchair (w/c) and sustained a "big bump" on her left forehead with skin abrasion to the left side of her face. On 2/22/17, noted left periorbital bruising remained and the resident was was sent to the emergency room and was admitted to the hospital with a UTI. R143 returned to the facility on 2/26/17, at which time a dark purple bruise was observed around her left eye. No further documentation was written about the brusing. R143's skin change reported dated 2/20/17, indicated a bruise and abrasion on the left orbit/facial area; treatment with ice packs was initiated.	F 309	Documentation Policy. Re-education provided to licensed nursing on revised Wound Documentation Policy. Weekly audits completed for 3 months to ensure compliance with monitoring skin changes. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 309	Continued From page 31 During an interview on 2/28/17, at 2:20 p.m. licensed practical nurse (LPN)-C explained R143 sustained the bruise to her left eye d/t a fall from her w/c about a week ago. LPN-C verified the nursing staff had not been monitoring the bruising for healing or worsening, but if they had been monitoring, it would have been documented on the MAR or TAR. LPN-C verified R143's bruise was not added to the MAR or TAR for monitoring. During an interview on 2/28/17, at 2:24 p.m. registered nurse (RN)-B explained R143's fall was recorded on video. R143 was emerging from her room unattended in her w/c. As she reached for the doorway to pull herself forward, she instead pulled herself off the w/c seat and fell onto the floor. RN-B verified R143's sustained a large bump to her forehead then the bruising continue to move downward the left side of her face. RN-B verified R143's bruise should have been added to her care plan and the MAR/TAR to ensure healing. The facility's 3/12, Skin Change Report policy indicated each resident's skin was observed by all nursing staff during cares. "Changes in a resident's skin is documented on a skin change report form."	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced	F 311		4/15/17

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F 311	Continued From page 32 by: Based on observation, interview and document review, the facility failed to provide grooming for 2 of 2 residents (R281, R269) who required oversight for grooming and were reviewed for activities of daily living (ADLs). Findings include: R281 was observed unshaven with a full growth on his cheeks, chin, and above his mouth 2/27/17, at 4:30 p.m. 2/28/17, at 10:22 a.m. 3/1/17, at 9:34 a.m. and 1:02 p.m. and 3/2/17, at 8:47 a.m. and 12:48 p.m. During the observations the resident was participating in meals and activities with other residents and visitors. R281's 12/6/16, Minimum Data Set (MDS) indicated the resident was severely cognitively severely impaired, but presented no behavioral problems or rejection of cares. R281's corresponding Care Area Assessment (CAA) dated 12/6/16, and current careplan indicated R281 needed staff assistance with grooming and bath/shower on Monday evenings. R281's most recent Body Audit--Bath Form dated 2/27/17, indicated vital signs and weight had been taken but showering and shaving was left blank. R269 was observed on 2/27/17, at 3:00 p.m. with long white chin hairs. R269 stated, "I am concerned about that. I need a tweezers. I have a couple real long ones here." R269 was unsure whether the staff would assist her in removing the unwanted facial hair. The following morning at 9:43 a.m. R269's chin hair was still present while the resident sat with other residents watching television. On 3/1/17, at 8:34 a.m. R269 had long chin hair and her hair appeared greasy and	F 311	Resident 281's care plan was reviewed. Resident 269's care plan was reviewed. An March 2, audit for all residents was completed to ensure grooming for facial hair was completed. Reviewed and revised Body Audit Policy and Form and Shaving the Resident Policy. Re-education provided to nursing assistants on the revised Body Audit Policy/Form and Shaving the Resident Policy. Weekly random audits completed for 3 months to ensure compliance with completing the body audit form and personal cares completed. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 311	Continued From page 33	F 311		

stringy while seated at breakfast with other residents. On 3/2/17, at 8:04 a.m. R269 was again at the dining table and facial hair was still present and her hair again appeared greasy and stringy.

R269's 1/25/17, Minimum Data Set (MDS) revealed the resident had moderately impaired cognition with no behavioral problems or rejection of cares. R269 required supervision/oversight with grooming. R269's current careplan indicated the resident historically refused bathing, but did take independent sponge baths in her bathroom. The goal was for the resident to be adequately groomed daily. Staff was directed to encourage R269 to bathe or shower on Sunday mornings, and to report refusals to the nurse. Set-up assistance was to be provided for grooming, and assistance provided if the resident did not complete the tasks on her own.

R269's nursing progress note dated 1/15/17, indicated "Day shift nurse reported that resident [R269] refused to take her shower on the day shift, evening staff have attempted to give resident a shower numerous time but have been unable to redirect, resident stated I will never take a shower because I one time I almost drowned."

A Care Conference note dated 2/1/17, indicated "Nsg: No recent concerns with [R269] just trying to get her to take a bath and allow us to wash her hair also indicated Social Service was "trying to talk to guardian to get some money here for res to get hair done at salon."

A Body Audit-Bath Form for R269 dated 2/12/17, indicated the resident's weight and vital signs were completed and shower refused. Shaving

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F 311	Continued From page 34	F 311		

and washed hair was blank. Bath form dated 1/29/17, indicated R269 allowed weight and vital signs to be completed and declined shower. Shaving and wash hair was left blank.

NA-D stated on 3/1/17, at 9:59 a.m. staff informed residents if they had facial hair, and assisted them to shave every morning and if staff did not have time then, residents would be shaved later in the shift. NA-D explained R269's hair was not washed on the day shift, but "maybe PM's [evening shift]." NA-D stated R269 told staff she did not want to take a shower, and had never showered at the facility. NA-D did not know why R269 resisted showering, but said she was sometimes resistive to cares depending on her mood.

NA-E then stated on 3/1/17, at 10:31 a.m. every time staff observed facial hair on a resident, they were required to assist the resident to shave. NA-E stated had assisted R269 that morning, but the resident had not allowed staff to brush her hair or teeth.

On 3/1/17, at 11:09 a.m. licensed practical nurse (LPN)-G stated NAs were supposed to shave residents "at least" on bath day but "should shave residents daily...It is a dignity thing."

NA-F reported on 3/2/17, at 8:07 a.m. preferring to shave residents when they got up, but it depended on the resident. NA-F explained that if a resident refused care, they re-approached the resident and notified the nurse who would then pass the information on to the evening shift. NA-F stated everyday she had observed R269's chin hair but stated the resident "refuses everything," including a shower, clean linen, and bathing

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F 311	Continued From page 35 because she reported she washed herself. On 3/2/17, at 8:54 a.m. LPN-A stated NAs shaved the resident on shower days and as needed. If a resident refused care they were re-approached and if they continued to refuse, the information was documented and passed on to the next shift. LPN-A stated staff were expected staff to fill out the body audit bath forms indicating which tasks had been completed. LPN-A stated R269 refused showers because she reported she had a shower where she had felt like she was drowning. At 10:32 a.m. LPN-A stated she had talked to R269 and the resident reported she wanted her hair washed at the beauty shop, so she planned to set this up with the beautician. LPN-A stated licensed social worker (LSW)-B planned to contact R269's guardian to request permission and money for the service. LPN-A stated she did not know if this had been completed, as LSW-B had been out ill. LPN-A stated, "I need to talk to [LSW-B] and the business office." The facility's 10/16, Shaving the Resident policy indicated the purpose of the policy was to remove facial hair and improve the resident's appearance and morale. The facility's 10/16, Hair and Scalp Care policy indicated the purpose was to clean hair and scalp, provide comfort, increase circulation, and to provide the resident with an attractive appearance and improve morale.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		4/15/17

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F 312	Continued From page 36 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming for 3 of 3 residents (R44, R197, R13) who were dependent on staffs' assistance and were reviewed for activities of daily living (ADLs). Findings include: R44 was observed on 2/27/17, at 3:05 p.m., 2/28/17, at 9:49 a.m., 3/1/17, at 8:35 and again at 10:45 a.m. with long facial hair. R44's quarterly MDS dated 2/1/17, indicated the resident had some memory problems, had no rejection of cares, and required extensive staff assistance with personal hygiene. R44's current careplan dated 8/13/16, indicated the resident needed assistance from one staff to perform grooming staff. R44's most recent Body Audit--Bath Form dated 2/16/17, indicated the resident had been assisted with shower but was not shaved. R13 was observed on 2/27/17, at 2:35 p.m. and on 2/28/17, at 3:31 p.m. and on 3/1/17, at 9:12 a.m. with multiple long chin hairs. R13's care plan dated 5/21/14, indicated the resident required physical assistance for ADLs related to cognitive impairment. Staff interventions were to assist the resident grooming. During an interview on 3/1/17, at 9:47 a.m. nursing assistant (NA)-B stated she was familiar	F 312	Resident 197, Resident 44, and Resident 13's care plan were reviewed and revised. An March 2, audit for all residents was completed to ensure grooming for facial hair was completed. Reviewed and revised Body Audit Policy and Form and Shaving the Resident Policy. Re-education provided to nursing assistants on the revised Body Audit Policy/Form and Shaving the Resident Policy. Weekly random audits completed for 3 months to ensure compliance. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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with R13 and provided cares to her that morning. NA-B explained R13 required staff assistance with ADL's at times she can help with her cares and if there are areas where she missed then staff will help do it. NA-B verified she washed R13 face and combed her hair this morning, then NA-B explained R13 will mess her hair up after they combed it as "she likes it that way." NA-B stated R13 was bathed or showered on Mondays and Wednesday mornings.

R13 was observed on 3/1/17, at 10:03 a.m. lying on bed. When R13 was asked if she would prefer to have her chin hair shaved, she felt her chin and said, "Yes." At 10:09 a.m. both NA-B and registered nurse (RN)-B entered R13's room and verified the presence of chin hair. NA-B stated she made a mistake early regarding R13 bath days. NA-B explained R13's bath days were Mondays and Thursdays not Wednesdays. Both RN-B and NA-B verified grooming should have been provided. The RN-B and the director of nursing both stated residents should have been well groomed.

A request of R13's Body Audit--Bath Forms were requested and only one was provided dated 2/13/16, indicating staff placed a check in the boxes of which services were provided for R13. The "shaved" box had been left un-checked.

R197's family member (FM)-A was interviewed on 2/27/17, at 3:50 p.m. FM-A was concerned R197 needed to use the bathroom at least every two hours or sooner, would self-transfer when she had to urinate and had fallen in the bathroom. FM-A reported R197's call light was also not always within her reach.

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MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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
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R197 was observed on 2/27/17, at 4:59 p.m. being wheeled into the dining room by FM-A who stayed for awhile then left. At 6:13 p.m. on 2/27/17, R197 was taken out of the dining room and brought to the television (tv) room. Four minutes later R197 self propelled herself down the hallway, into her room, open up the bathroom door, when inside and shut it. At 6:19 p.m. the room after R197's call light was activated where licensed practical nurse (LPN)-B walked by R197's room without looking in and answered the activated light next door. While LPN-B was assisting the resident next door, R197 came out of her bathroom and wheeled herself over to her tv to watch a program. At 6:26 p.m. LPN-B left the room next door and noticed R197 in her room, he went into R197 room and asked if she had to use the bathroom, R197 replied "I already did." LPN-B said, "Next time can you ask someone first. Don't do it by yourself."

R197's annual Minimum Data Set (MDS) dated 12/14/16, indicated R197 had cognitive impairment, and did not refuse care. R197's care plan dated 2/16/17, indicated diagnoses of dementia, left side hemiplegia (paralysis on half the body) due to a stroke and urinary incontinence with urgency of urination with the need for one staff to assist with toileting. Staff intervention included providing every two hour toileting, "anticipate resident's needs, direct to use call light for assistance and wait for assistance." The care plan dated 7/27/15, indicated "Resident has been seen hiding her call light in her bed. Call light moved from visible area on bed to between mattresses while staff not in resident room. shorter call light installed to prevent resident from reaching."

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R197 was interviewed on 2/27/17, at 6:31 p.m. and stated she was able to take herself to the bathroom, did not need any staff's help. She denied falling and said she knew where her call light was and how to use it. The call light was observed clipped to the middle of R197's bed.

R197 was observed continuously on 3/1/17, from 7:11 a.m. to 9:51 a.m. R197 was already in her wheel chair, dressed and placed in the dining room for breakfast at 7:11 a.m. At 7:18 a.m. nursing assistant (NA)-C was interviewed inside the dining room. NA-C verified he was taking care of R197 today and stated he got her up around 6:45 a.m. NA-C stated R197 needs help with her ADL's, and said, "went I toileted her this morning she was able to stand, hold onto the grab bars and urinated into the toilet." NA-C stated R197 will wheel herself down to her room after breakfast, put on her call light if she needs to use the bathroom. At 7:24 a.m. R197 was wheeled out of the dining room and brought to her room by registered nurse (RN)-A to be administered medication. RN-A gave the medication and brought R197 back to the dining room at 7:27 a.m. At 7:53 a.m. dietary was present and started to set up breakfast at 8:06 a.m. R197 received her breakfast plate. At 8:37 a.m. R197 self-propelled self to look out the window then back to the table and continue to eat. At 9:07 a.m. therapeutic recreation came to take resident out for exercise and asked R197 if she was still eating, she nodded her head yes. At 9:22 a.m. RN-A asked R197 is she was still eating , she replied "yes." At 9:34 a.m. dietary came to clean the dining room and asked R197 is she was done eating she said, "yes" and her plate was taken away, but she continued to finish her hot chocolate. At 9:41 a.m. R197 was wheeled

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back to her room by RN-A. RN-A verified he did not ask R197 if she needed to use the toilet nor did he offer to take her, he explained she will let us know when she has to use the bathroom. RN-A placed R197 in front of her tv, turned on a program and said to R197, "let us know if you have to go to the bathroom, don't do it yourself, call for help then left the room. At 9:51 a.m. RN-A entered R197's room and asked if she had to use the bathroom, she said, "yes" RN-A closed the door and assisted her to the bathroom.

A follow-up interview on 3/1/17, at 9:57 a.m. with NA-C A follow-up interview on 3/1/17, at 9:57 a.m. with NA-C verified R197's toileting schedule is every two hours. NA-C explained R197 is able to let staff know 85% of the time when she had to use the bathroom. When it was brought to NA-C attention that it had been over two and half hours since R197 was asked, offered or taken to the bathroom. NA-C said, "I asked [R197] if she had to use the bathroom when she was at breakfast." When it was brought to his attention that a continuous observation was done that morning. NA-C verified he in fact did not ask R197 due to he was busy getting other resident up for the morning and R197 should have been offered toileting.

RN-B explained on 3/1/17, at 10:09 a.m. she expected staff to follow each resident's care plan and if a resident was to be toileted every two hours then staff should be doing it. RN-B verified R197's FM-A voiced his concerns that he would like his mother toileted after every meal right away because he was afraid she will self-toilet and fall. RN-B stated she was unsure why staff did not toilet R197 per her care plan.

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F 312	Continued From page 41 Surveyor: Teipel, Jane Nursing assistant (NA)-D stated on 3/1/17, at 9:59 a.m. staff informed residents if they had facial hair, and assisted them to shave every morning and if staff did not have time then, residents would be shaved later in the shift. NA-E then stated on 3/1/17, at 10:31 a.m. every time staff observed facial hair on a resident, they were required to assist the resident to shave. On 3/1/17, at 11:09 a.m. licensed practical nurse (LPN)-G stated NAs were supposed to shave residents "at least" on bath day but "should shave residents daily...It is a dignity thing." NA-F reported on 3/2/17, at 8:07 a.m. preferring to shave residents when they got up, but it depended on the resident. NA-F stated she had noticed R44 had chin hair, but had been "a little agitated" that morning so would then try to assist the resident after breakfast. NA-F explained that if a resident refused care, they re-approached the resident and notified the nurse who would then pass the information on to the evening shift. On 3/2/17, at 8:54 a.m. LPN-A stated NAs shaved the resident on shower days and as needed. If a resident refused care they were re-approached and if they continued to refuse, the information was documented and passed on to the next shift. LPN-A stated staff were expected staff to fill out the body audit bath forms indicating which tasks had been completed. R197's family member (FM-A) reported concerns regarding R197's care at the facility on 2/27/17, at 3:50 p.m. FM-A explained R197 needed to use	F 312		

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the toilet every two hours or sooner, or she self-transferred and had experienced falls in the bathroom. Staff did not also ensure R197's call light was within reach.

R197 was assisted to the dining room by FM-A on 2/27/17, at 4:59 p.m. FM-A visited a while and then left. Following dinner at 6:13 p.m. R197 was assisted out of the dining room and to the television area. Four minutes later R197 was observed propelling herself down the hallway to her room, opened the bathroom door, went inside the bathroom and shut the door. At 6:19 p.m. the call light in the adjacent room was activated and answered by licensed practical nurse (LPN)-B, who walked past R197's room without looking into the room to answer the other resident's call light. While LPN-B was assisting the resident next door, R197 emerged from the bathroom and wheeled herself in front of her television. At 6:26 p.m. LPN-B noticed R197 was in her room and asked if she needed to use the toilet to which R197 responded, "I already did." LPN-B asked, "Next time can you ask someone first? Don't do it by yourself," and then left the room.

R197 was interviewed on 2/27/17, at 6:31 p.m. and reported she was able to take herself to the toilet, and denied needing staffs' assistance. R197 also denied experiencing falls, and said she knew where to find her call light and how to use it. At the time of the interview the call light was observed clipped onto the middle of the bedspread.

R197 was observed continuously on 3/1/17, from 7:11 to 9:51 a.m. R197 was in her wheelchair and in the dining room waiting for breakfast at 7:11 a.m. At 7:18 a.m. nursing assistant (NA)-C

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verified he was assigned to care for R197, and said he had assisted her out of bed at around 6:45 a.m. NA-C stated R197 needed help with activities of daily living. When toileted that morning, NA-C said R197 was able to stand, hold onto the grab bars and urinate in the toilet." NA-C stated R197 wheeled herself to her room after breakfast and put on her call light if she needed to use the toilet. At 7:24 a.m. R197 was wheeled out of the dining room to her room by registered nurse (RN)-A, her medications were administered in her room, and then she was assisted back to the dining room 7:27 a.m. t 8:37 a.m. R197 wheeled to the window, looked out, and then wheeled back to the table to resume eating. At 9:07 a.m. a therapeutic recreation staff entered the dining room to assist R197 to exercise activity. When asked if she was still eating, R197 nodded "yes." At 9:22 a.m. RN-A asked R197 is she was still eating and she replied "yes." R197 was assisted back to her room at 9:41 a.m. by RN-A. RN-A verified he had not asked nor had he taken R197 to the toilet, and explained "She will let us know when she has to use the bathroom." RN-A turned on the television for R197 and informed her, "Let us know if you have to go to the bathroom. Don't do it yourself. Call for help," and then left the room. At 9:51 a.m. RN-A entered R197's room and asked if she had to use the bathroom, she replied, "yes." RN-A then assisted R197 to use the toilet, more than three hours after she had been assisted with morning cares at approximately 6:45 a.m.

In a follow-up interview on 3/1/17, at 9:57 a.m. NA-C verified R197's toileting schedule was every two hours. NA-C explained R197 was able to let staff know "85% of the time" when she needed to use the toilet. When it was brought to NA-C's

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attention it had been greater than two hours since R197 had been offered the toilet, NA-C said he had asked her when she was eating breakfast. When the surveyor reported having continuous observations of R197 at breakfast, NA-C reported being too busy with other residents that morning and he had in fact not offered R197 toileting, but should have done so.

During an interview on 3/1/17, at 10:09 a.m. RN-B explained she expected staff to follow the resident's individualized care plan, and if they were to be toileted every two hours, then staff "should be doing it." RN-B verified R197's FM-A had expressed concerns he would like R197 toileted right away following meals as he was concerned she would self-transfer and fall. RN-B was not sure why toileting had not been provided according to R197's care plan.

NA-C verified on 3/2/17, at 9:23 a.m. he was aware R197 sometimes self-transferred to the toilet.

R197's annual Minimum Data Set (MDS) dated 12/14/16, indicated the resident had diagnoses including dementia and was severely cognitively impaired, but did not display behavioral symptoms or refuse care. R197 was occasionally incontinent and required extensive assistance of one staff to transfer and use the toilet.

R197's care plan dated 2/16/17, also indicated diagnoses of dementia, as well as hemiplegia (paralysis on half the body) due to a stroke and urinary incontinence with urgency (inability to hold urine). R197 required one staff to assist her with toileting. Staff was directed to assist R197 to use the toilet every two hours, to anticipate her needs,

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F 312	Continued From page 45 instruct R197 to use the call light to ask for help and to wait for staffs' assistance. Additionally the care plan dated 7/27/15, indicated "Resident has been seen hiding her call light in her bed. Call light moved from visible area on bed to between mattresses while staff not in resident room. Shorter call light installed to prevent resident from reaching." The facility's 10/16, Shaving the Resident policy indicated the purpose of the policy was to remove facial hair and improve the resident's appearance and morale. The facility's 10/16, Hair and Scalp Care policy indicated the purpose was to clean hair and scalp, provide comfort, increase circulation, and to provide the resident with an attractive appearance and improve morale. The facility's 10/16, AM Cares policy the purpose was to provide cleanliness, comfort, and neatness. To monitor residents condition and promote psychosocial well-being. Staff were instructed to wash resident's face and straighten and/or change all bed linens as needed.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 314		4/15/17

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F 314	Continued From page 46 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure repositioning was provided to minimize the risk for skin breakdown for 1 of 1 resident (R197) who was reviewed for pressure ulcers. Findings include: R197 was interviewed on 2/27/17, at 6:31 p.m. She stated she did not require help from staff, denied experiencing any falls, and said she knew how to locate and use her call light if she needed help. R197's call light was observed clipped to the middle of her bedspread. R197 was observed continuously on 3/1/17, from 7:11 to 9:51 a.m. R197 was up in her wheelchair, dressed and was seated in the dining room at 7:11 a.m. At 7:18 a.m. nursing assistant (NA)-C was interviewed and stated he was assigned to care for R197 that day, and had assisted the resident out of bed at approximately 6:45 a.m. NA-C explained R197 required assistance with activities of daily living including toileting and said, "When I toileted her this morning she was able to stand, hold onto the grab bars and urinated into the toilet." NA-C stated R197 was able to wheel herself back to her room after breakfast, and would put on her call light if she needed help to	F 314	Resident 197's care plan reviewed and revised. To ensure other residents are not at risk facility wide audits have begun. Reviewed and revised Positioning the Resident Policy and Individualized Care Plan and Care Cards Policy. Re-education provided with licensed nursing and nursing assistants on the revised Positioning the Resident and Individualized Care Plan and Care Cards policies. Weekly random audits on each unit completed for 3 months to ensure compliance. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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use the toilet. At 7:24 a.m. R197 was assisted back to her room from the dining room by registered nurse (RN)-A. RN-A then gave R197 her medications and returned the resident to the dining room at 7:27 a.m. The dining service began at 8:06 a.m. At 8:37 a.m. R197 propelled her wheelchair to look out the window, and then returned to the table and continued eating. At 9:07 a.m. a therapeutic recreation staff person told R197 she would assist her to the exercise activity, but asked whether she was still eating her breakfast. R197 nodded her head "yes." At 9:22 a.m. RN-A asked R197 if she was still eating, to which she replied, "yes." At 9:34 a.m. a dietary aid began cleaning the dining room and R197 informed her she was finished eating, but continued to drink her beverage. At 9:41 a.m. R197 was assisted back to her room by RN-A. RN-A verified he did not ask R197 if she needed to use the toilet nor did he offer to take her, but explained the resident would let staff know if she needed to use the toilet. RN-A then told R197, "Let us know if you have to go to the bathroom. Don't do it yourself. Call for help." RN-A then left the room. At 9:51 a.m. RN-A re-entered R197's room and asked if she needed to use the toilet. R197 replied, "Yes," and the nurse then assisted her to use the toilet.

R197's annual Minimum Data Set (MDS) dated 12/14/16, indicated the resident had cognitive impairment, but showed no behavior symptoms or refusal of cares. R197's care plan dated 2/16/17, indicated the resident had diagnoses including dementia, as well as left-sided hemiplegia (paralysis on half of the body) due to a stroke. In addition, the care plan dated 1/22/15, indicated R197 had potential for an alteration in skin integrity due to decreased mobility. Staff was

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directed to turn and reposition the resident every two hours while in the chair and bed, anticipate the resident's needs, and instruct the resident to use the call light and wait for staffs' assistance.

In a follow-up interview on 3/1/17, at 9:57 a.m. NA-C verified R197's repositioning schedule included assisting the resident to use the toilet. NA-C said R197 was able to let the staff know she needed the toilet "85 percent of the time." NA-C explained the nursing assistants were provided information about each resident on the iPad communication device they were provided. However, NA-C did not have his iPad and stated it was because "I worked with her for a long time so I know what she needs." When it was brought to NA-C's attention that it had been greater than two and half hours since R197 was asked, offered or was assisted to the toilet NA-C replied, "I asked if she had to use the bathroom when she was at breakfast." When the surveyor said continuous observations of R197 had been conducted NA-C verified he was busy assisting other residents and had not asked R197 if she needed to use the toilet, but should have offered.

During an interview on 3/1/17, at 10:09 a.m. RN-B explained she expected staff to follow each resident's care plan. If a resident was supposed to be repositioned every two hours, then the expectation would be the resident would be repositioned every two hours. RN-B stated she was unsure why staff did not reposition R197 per her care plan.

The facility's 12/13, Positioning The Resident policy indicated the purpose was to relieve pressure and prevent skin breakdown. The policy instructed staff with step by step directions as to

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F 314	Continued From page 49 how to reposition a resident in multiple positions.	F 314		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's	F 328		4/15/17

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MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

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F 328	Continued From page 50 goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate nutrition/fluids was provided for 1 of 1 resident (R23) who received nutrition/fluids via an enteral feeding tube. Findings include: R23's face sheet revealed diagnoses including diabetes and dysphagia oropharynngeal (swallowing disorder) and a gastrostomy (g-tube feeding). R23's care plan dated 9/19/16, revealed the resident had a potential alteration in nutrition related to advancing amyotrophic laterals sclerosis (ALS) with hospice care, as well as dysphagia/aspiration pneumonia and G-tube feedings. The care plan instructed staff to "monitor percentage of food intake." The resident	F 328	Resident 23's care plan reviewed. Dietitian and NP were notified. Audited other residents receiving Enteral Nutrition to ensure compliance with policy. Reviewed and revised Enteral Nutrition Policy. Re-education with licensed nursing on the revised Enteral Nutrition Policy. Weekly audits of all residents on tube feeding completed for one month to ensure compliance with policy. A summary of the audits will be reviewed at the Quality Assurance & Performance	

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F 328	Continued From page 51 could also have a regular diet/pleasure foods such as pudding. Physician orders included Glucerna 1.5 (enteral nutrition for persons with diabetes) at 105 cc's/hour for 12 hours (a total of 1260 cc's), followed by water flushes 225 cc's four times daily. R23's admission Minimum Data Set (MDS) dated 9/23/16, revealed the resident was cognitively intact. R23 also had a swallowing disorder, and received nutrition via a feeding tube and a mechanically altered diet. Her percent of intake via tube feeding was greater than 51% and she received 501 cc's or more via tube feeding. R23 was observed in bed on 2/28/17, at 8:17 a.m. R23's tube feeding was dripping into the trash can next to the resident's bed. Licensed practical nurse (LPN)-C was informed of the observation and stated, "I did not disconnect the feeding tube" and said the resident must have disconnected it herself. LPN-C stated the resident "does that, unfortunately." LPN-C said the staff performed room checks every two hours, and occasionally R23 used her call light to summon help. LPN-C explained R23's tube feeding schedule started at 8:00 p.m. and ended at 8:00 a.m. LPN-C stated, "I did not start the tube feeding--it must be from the night shift." LPN-C confirmed 200 cubic centimeters (cc's) remained in the bag, and then threw the bag with the remaining contents and tubing into the trash can. R23 was again observed on 3/1/17, at 7:13 a.m. R23 was crying and her tube feeding was again disconnected from the source. The tube feeding machine was running, and the fluid was dripping onto the floor. There was approximately 500 cc's remaining in the bag. At 7:51 a.m. registered	F 328	Improvement (QAPI) Committee for 1 month and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 328	Continued From page 52	F 328		

nurse (RN)-G entered to R23's room and explained she was going to give R23 her medication. RN-G then observed the tube feeding dripping on the floor and stated, "Oh the tube feeding machine is on the floor" and verified the fluid was dripping onto the floor. RN-G said 400 cc's remained in the bag and she threw it in the trash can. R23 was again crying, and RN-G stated, "I do not know why she is crying."

RN-F who was present on the night shift was interviewed on 3/1/17 at 7:13 a.m. RN-F stated during the night shift she checked on R23 and provided appropriate monitoring. R23 did not typically use her call light, therefore RN-F stated, "I usually assess her at the beginning of the shift and then every hour. If the resident is sleeping we let her sleep...." RN-F stated the staff alternated checking on R23 every hour between the NAs and nurse. The NAs would then let the nurse know of any problems right away. RN-F explained that at approximately 6:00 a.m. R23's tube feeding was running appropriately, but then the resident tried to go to the other side of the bed and it disconnected. RN-F stated, "I tried to put it back" in, but the resident refused. At 8:23 a.m. RN-F stated, "I probably left the tube on. I forgot to shut it off." When RN-F asked how staff knew how much nutrition and fluid R23 had received RN-F explained the resident should have received 105 cc's per hour. RN-F said that at about 12:30 a.m. there was approximately 500 cc's left in the bag. RN-F then added two additional cans (240 cc's per can) for a "total of 974 cc's."

On 3/1/17, at 8:10 a.m. RN-G took the medication back to the medication cart and stated, "I will give [R23's] medication when she calms down." At

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F 328	Continued From page 53	F 328		

9:21 a.m. RN-G said the night nurse had not reported R23's tube feeding had been disconnected, only that R23 was "screaming and crying at around 6:00 a.m." When asked how staff would know if the resident was receiving adequate nutrition and fluids according to the physician's order, RN-G stated, "I am not sure. I usually look at how much left in the bag and disconnect and throw it away. Maybe she gets 1000 cc's over 12 hours." RN-G explained the evening nurse started the tube feeding and the day shift nurses disconnected it at 8:00 a.m. RN-G then checked R23's physician orders and told the surveyor the resident "gets around 1500 cc's over 12 hours--I threw out 400 cc's in the bag and I will guess there was about 100 cc dripped on the floor, which I already cleaned up."

R23's Progress Note dated 3/1/17, at 8:47 a.m. indicated "Resident received total of 735 ml [cc's] from 11 pm till 0600 [6:00 a.m.]...."

The registered dietitian (RD) stated on 3/2/17, at 9:13 a.m. regarding R23's tube feeding, "I assume she get her feeding per the order [105 cc's per hour for 12 hours, 1260 cc's per day from 8:00 p.m. to 8:00 a.m.]. Nobody notified me the resident removes the tube feeding--never heard--nobody notified me."

RN-B stated on 3/2/17, at 10:29 a.m. "Yes, the staff reported to me that resident disconnected her G-tube. It doesn't happened often." RN-B said, "It is hard to know the amount dripped on the floor. She did not get the whole amount ordered." RN-B further explained the hospice nurse, dietitian and physician would have been updated if the problem was ongoing. RN-B stated, "I don't think this is a pattern for us to let

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F 328	Continued From page 54 the dietitian know." The director of nursing stated on 3/2/17, at 12:35 p.m. "They should base how much is left in the bag, but it is hard to know the amount spilled on the floor. It is concerning to me [appropriate staff] was not notified about what is happening." The facility's 12/13, Enteral Feeding Nutrition policy indicated the purpose of the policy was "1. To provide liquid nourishment, through a tube, into the stomach. 2. To provide adequate hydration." The policy directed staff to "Document on record that placement was verified, amount of residual feeding/meds [medications] were administered."	F 328		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 334		4/15/17

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F 334	Continued From page 55 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 334		

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F 334	Continued From page 56 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 5 of 5 residents (R31, R119, R134, R139 and R314) or their legal representative were provided required education regarding the risks and benefits and potential side effects of influenza and pneumococcal immunization prior to administering the vaccinations. Findings include: Immunization records were reviewed on 3/1/17, and the following was noted: R31 received the influenza vaccine on 10/31/16, and received the pneumococcal 13 on 11/18/16. R119 received the influenza vaccine on 10/12/16, and received the pneumococcal 13 on 10/26/16. R134 received the influenza vaccine on 10/14/16, and received the pneumococcal 13 on 11/22/16. R139 received the influenza vaccine on 10/5/16, and received the pneumococcal 13 on 10/14/16. R314 received the influenza vaccine on 9/30/16, and received the pneumococcal 23 on 1/31/17. All five residents immunization records lacked documentation of education regarding the potential side effects and the risks and benefits of the influenza and pneumococcal immunizations prior to administering the vaccinations.	F 334	Resident 31, Resident 119, Resident 134, Resident 139 and Resident 314 already had the vaccinations administered. We did monitor all residents for signs and symptoms of adverse reactions to the vaccination. Reviewed Resident Pneumococcal Vaccination Policy and Resident Vaccination Influenza Policy. Re-education provided with licensed nursing on Resident Pneumococcal Vaccination Policy and Resident Vaccination Influenza Policy Weekly random audit completed for a month to ensure compliance with policies. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for one month and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 334	Continued From page 57 The director of nursing (DON) explained on 3/1/17, at 1:02 p.m. letters had been sent to residents' family members. The DON stated she was aware the facility needed to maintain evidence risk/benefit information was provided and the resident or representative consented to vaccination. The DON verified R31's, R119's, R134's, R139's and R314's immunization record lacked such documentation. On 3/8/17, the DON emailed information stating the Minnesota Department of Health Vaccine--preventable disease information had been sent out to resident representatives on 9/26/16, for the 2016/17 influenza season. The information was dated 10/15, and was for the 2015/16 influenza season. The facility's 11/16, Resident Vaccine-Influenza policy indicated at the time of admission "The resident and/or representative will received influenza vaccine information statement (VIS) and sign an acknowledgement form. Before the resident receives the vaccine, the nurse will verify that they have received the VIS." The facility's 1/17, Resident Pneumococcal Vaccine policy directed staff, "Before administering the vaccine, the nurse will verify resident and/or responsible party has been offered the VIS."	F 334		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 356		4/15/17

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F 356	Continued From page 58 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse	F 356		

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F 356	Continued From page 59 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure posted nursing hours included required information, potentially affecting the 129 residents and visitors. Findings include: Required information was missing on the posted nursing hours when observed on 2/27/16. The posted hours did not include the facility's census, nor the total nursing assistant hours for overnight shift. During interview on 3/1/17, at 11:11 a.m. the staffing coordinator (SC) stated, "We have a shared drive and the night supervisor updates the census and nursing hours for the morning shift and then when I come I will update it for the evening shift, and finally the evening supervisor updates it for the night shift posting." When asked if the current posting was complete for Monday, 2/27/17, the SC replied, "I see it is missing the long term care census [for the overnight shift]...I do not know why the Long Term Care census and nursing assistant hours was not updated." On 3/1/17, at approximately 11:30 a.m. the director of nursing stated, "I expect the night shift to update census posting for the day shift, the day shift to update for the evening, and finally the evening shift update for the night shift. It must be done accurately." The DON verified the posting for 2/27/17, was missing the Long Term Care census and nursing	F 356	Facility updated staffing posting immediately. Reviewed Nursing Staffing Hours Policy. Re-education provided with staffing coordinator and house supervisors for posting hours. Weekly random audits completed for 3 months to ensure compliance. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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F 356	Continued From page 60 assistant hours. The DON stated, "We are missing the night shift nursing assistant hours and the census. I know this is a problem." The facility's 2/16, Nursing Staffing Hours policy was "To ensure that the nursing hours are available to the public and for resident to review" and to comply with the regulation. "The facility must post the following information daily at the beginning of each shift for 24 hour period. a. Facility name b. The current date c. resident census d. the total number and actual hours worked."	F 356		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		4/15/17

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F 441	Continued From page 61 before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an	F 441		

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F 441	Continued From page 62 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure multi-use glucometers were disinfected to minimize the potential spread of infection for 3 of 3 residents (R313, R95, R80) who utilized a shared glucometer, and potentially affecting the eight residents who shared the glucometers. Findings include: R313's blood glucose was checked on 3/1/17, at 12:38 p.m. by registered nurse (RN)-C. RN-C applied gloves, wiped off R313's fingertip with an alcohol wipe, poked the finger with a lancet and squeezed until a drop of blood appeared on the test strip. After reading the glucometer blood sugar RN-C took the strip out of the glucometer, rolled it into the soiled gloves and disposed of them in the wastebasket. RN-C took a Super Sanicloth and wiped around the glucometer for approximately 3-5 seconds and stated, "I am to let the glucometer dry for two minutes," as she waved her hand back and forth over the glucometer and then set it down. RN-C stated she had used the same glucometer on two residents that day and stated normally she used the same glucometer on three residents, but one resident was out of the building. Later at 1:06 p.m. licensed practical nurse (LPN)-E stated when she cleaned glucometers she obtained a couple of paper towels, put on new gloves, wiped all around the device with a Super Sanicloth, disposed of the wipe, and then laid the glucometer down on the paper towels to	F 441	Resident 313, Resident 95, Resident 80 and all resident in the facility using glucometers were given personal use glucometers. Reviewed Blood Glucose Disinfection Policy. Re-education provided with licensed nursing and trained medication assistants on Blood Glucose Disinfection Policy. Weekly random audits to be completed for 3 months to ensure compliance with cleaning glucometers. A summary of the audits will be reviewed at the Quality Assurance & Performance Improvement (QAPI) Committee for 3 months and the recommendations from the Committee will be followed. The Director of Nursing is responsible for compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 441	Continued From page 63	F 441		

dry for 1-2 minutes before re-using it on another resident. LPN-E stated the glucometer used on the unit was a shared glucometer utilized by four residents.

R95's blood glucose was checked on 3/1/17, at 11:26 a.m. by LPN-D. LPN-D washed her hands, applied gloves, obtained a blood sample via a fingerstick from R95's finger and touched the end to the glucometer stick. After obtaining the numeric results, LPN-D removed her gloves, washed her hands,applied a new set of gloves, obtained a Super Sanicloth and wiped down the glucometer for 20 seconds, and then disposed of the wipe. LPN-D then placed the glucometer on a paper towel and returned it to the nursing cart. LPN-D stated the policy for glucometer cleaning was "If the machine is visibly soiled we wipe it twice. If not we wipe it once, then let it air dry for two minutes."

80's blood glucose was then checked on 3/1/17, at 11:37 a.m. by LPN-D. LPN-D performed the same steps as she did for R95, but wiped the glucometer machine for 15 seconds before returning it to the nursing cart and placing it on a paper towel to dry.

At 12:20 p.m. the director of nursing (DON) provided the facility's policy for cleaning glucometers. The DON explained after the nurse was finished using the machine, it was to be cleaned using a Super Sanicloth wipe. They wiped it twice if the glucometer was visibly soiled, and once if it was not. The nurse then ensured it remained visibly wet for two minutes. The DON said she would check the manufacturer's recommendation regarding ensuring the machine was visibly wet for two minutes. The

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F 441	Continued From page 64 manufacturer's recommendations were not provided. On 3/1/17, at 12:29 p.m. LPN-D reported she wiped the meter once and it stayed wet--"not dripping wet, but wet." When asked to repeat the cleaning process, LPN-D wiped the meter a few times, and placed it on a paper towel. The meter was visibly wet for 45 seconds versus two minutes. On 3/1/17, at 12:48 p.m. the DON verified that just wiping the meter once and letting it air dry would not have ensured the glucometer stayed visibly wet for two minutes. The facility's 7/12, Cleaning/Disinfecting Blood Glucose Monitor and INR [also used to test blood] Machine indicated equipment required included appropriate cleaner wipes, gloves and two paper towels. Staff was instructed step-by-step on how to clean the machine as follows: "Disinfected the machine with appropriate cleaner wipes at point of service, if the machine is visibly soiled clean it twice, the treated surface must remain visibly wet for a full two minutes or per manufacturer, use additional wipes as needed to assure wet contact time and let air dry."	F 441		

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET BLOOMINGTON, MN 55425**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 06, 2017. At the time of this survey, Martin Luther Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) building was completed in 2010 and a 1-story, Type II (000) building was completed in 2011. The building construction of the 1984 and 2011 building are compatible and will be surveyed as one building. The 2010 Type V(111) building will be surveyed as a separate building. The facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 137 beds and had a census of 127 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

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

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2017**

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	245272	A. BUILDING **03 - NEW RESIDENCE** B. WING _____	**03/06/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 06, 2017. At the time of this survey, Martin Luther Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. In addition, a 1-story, Type V (111) building was completed in 2010 and a 1-story, Type II (000) building was completed in 2011. The building construction of the 1984 and 2011 building are compatible and will be surveyed as one building. The 2010 Type V(111) building will be surveyed as a separate building. The facility is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 137 beds and had a census of 127 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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