DEPARTMENT OF HEALTH AND H	HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 5S8S
PA	RT I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00394
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245369		3. NAME AND AL (L3) ST MARKS	LUTHERAN	HOME		 TYPE OF ACTION: <u>7</u>(L8) Initial 2. Recertification
 STATE VENDOR OR MEDICAID NO. (L2) 055842700 		(L4) 400 - 15TH A (L5) AUSTIN, M		JTHWEST	(L6) 55912	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 02/16/2017		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:() 0 Unaccredited 1 TJC 2 AOA 3 Other	L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of 7	The Following Requirements:
To (b):		0	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
	1.10)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
12.Total Facility Beds 61 12.Total Facility Beds 61					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds 61 (1	L17)	B. Not in Comp Requirements	and/or Applied		* Code:	(L12)
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS	
18 SNF 18/19 SNF 1	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
61						
	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF A	APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Marietta Lee, HFE NE II		0	4/18/2017	(L19)	Kamala Fiske-Downing, E	nforcement Specialist 4/18/2017 (L20)
PART II - T	O BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITI ITS ACT:	H CIVIL		cial Solvency (HCFA-2572) 1 Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Participate		KIOP	113 ACT:		3. Both of the Above	· · · · · · · · · · · · · · · · · · ·
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE 23. LTC	AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEG 12/01/1986	SINNINC	6 DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTI	ERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>
A. St	uspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27) B. Re	escind Su	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
(L28)				(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	DATE		
(L32)				(L33)	DETERMINATION APPR	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245369

April 14, 2017

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

Dear Mr. Finger:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 8, 2017 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 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,

Kumalu Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

February 21, 2017

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

RE: Project Number S5369026

Dear Mr. Finger:

On February 16, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on February 16, 2017, imposed a daily fine in the amount of \$250.00.

A reinspection was held on February 16, 2017 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$250.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$46.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$296.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Kumala Fiske Downing

St Marks Lutheran Home February 21, 2017 Page 2 Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REV	/ISIT
	B. Wing	Y2	2/16/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWEST		
		AUSTIN, MN 55912		

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

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
483.65 Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/16/2017			LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC				LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GPN/kfd	DATE	SIGNATURE OF SURVEYOR		DATE
		02/21/2017		15425	2/16/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 11/17/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 21, 2017

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

RE: Project Number 5369026 and Complaint Number H5369059

Dear Mr. Finger:

On December 12, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective December 17, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on November 17, 2016 that included an investigation of complaint number H5369059. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 19, 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 November 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 17, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on November 17, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On February 16, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 19, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 19, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 16, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

St Marks Lutheran Home February 21, 2017 Page 2

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February
- 21, 2017 be rescinded effective February 16, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of December 12, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 17, 2017.

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,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00394 _{Y1}	B. Wing	Y	(2	2/16/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
ST MARKS LUTHERAN HOME	<u>.</u>	400 - 15TH AVENUE SOUTHWEST			
		AUSTIN, MN 55912			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix 21375	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0 Subp. 1	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/16/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
	GPN/kfd	2/21/2017		15425	2/16/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 11/17/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567)		

DEPARTMENT OF HEALTH AND HUN	IAN SERVICES	CENTERS FOR MED	DICARE & MEDICAID SERVICES
	ICARE/MEDICAID CERTIFICATION		ID: 5S8S
PART	I - TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00394
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245369	3. NAME AND ADDRESS OF FACILITY (L3) ST MARKS LUTHERAN HOME		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
 STATE VENDOR OR MEDICAID NO. (L2) 055842700 	(L4) 400 - 15TH AVENUE SOUTHWEST (L5) AUSTIN, MN	Г (L6) 55912	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/19/2017 (L34)		14 CORF	
8. ACCREDITATION STATUS: (L10)			FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a):	A. In Compliance With	And/Or Approved Waivers Of	
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel	6. Scope of Services Limit
		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 61 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN	
13.Total Certified Beds 61 (L17)	X B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room
	Requirements and/or Applied Waivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SN	NF ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
61			
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPI 17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Kyla Einertson, HFE NE II	01/31/2017 (L19)	Kamala Fiske-Downing, E	
PART II - TO E	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)
1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible		5. Bour of the ridove	·
(L2	1)		
22. ORIGINAL DATE 23. LTC AGR	EEMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINN	ING DATE ENDING DATE	VOLUNTARY 00	INVOLUNTARY
12/01/1986		01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERN	ATIVE SANCTIONS	03-Risk of Involuntary Terminatio	n <u>OTHER</u>
A. Susper	nsion of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27) P. Passir	(L44)		00-Active
B. Rescin	d Suspension Date:		
20. TEDMINATION DATE.	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPE	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 20, 2017

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

RE: Project Number S5369026

Dear Mr. Finger:

On December 12, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective December 17, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on November 17, 2016. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 19, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 22, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on November 17, 2016.

However, compliance with the health deficiencies issued pursuant to the November 17, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey

St Marks Lutheran Home January 20, 2017 Page 2

identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 17, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 17, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Marks Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 17, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services

St Marks Lutheran Home January 20, 2017 Page 3

> Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov

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 electronic plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> Telephone: (507) 206-2731 Fax: (507) 206-2711

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.

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

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 May 17, 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: St Marks Lutheran Home January 20, 2017 Page 4

> 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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED
		245369	B. WING				R 1 9/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	01/	10/2011
ST MAR	(S LUTHERAN HOME	:			00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}			
{F 441} SS=D	completed on 1/19/ were corrected can Also there are tag/s at the time of onsite the CMS2567. Because you are en- signature is not req page of the CMS-2: submission of the F verification of comp Upon receipt of an on-site revisit of you validate that substa- regulations has bee your verification. 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to	acceptable electronic POC, an ur facility will be conducted to initial compliance with the en attained in accordance with I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective	{F 44	41}			2/8/17
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						01/31/2017

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

PRINTED: 01/31/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM /	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			COMF	E SURVEY PLETED	
		245369	B. WING			F 01/1	≺ 19/2017
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	:			00 - 15TH AVENUE SOUTHWEST		
•••••				A	AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	 (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility music communicable dise from direct contact direct contact will trend (3) The facility music hands after each di hand washing is incorprofessional practice (c) Linens Personnel must har 	ad of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted	{F 4	41}			
	by: Based on interview failed to operationa program/policy in re- resolution for Urinal of 4 residents (R40 experienced UTIs. Findings included: The facility's Month and Monthly Infection provided on 1/19/17 logs. The following 12/2016 there were UTIs	NT is not met as evidenced and record review, the facility lize their infection control egards to completing the ry Tract Infections (UTIs) for 2 and R2) reviewed who hy Infection Control Reports on Logs were requested and 7 from 12/2016 and 1/2017 was included on these logs: 3 infections with two being 6 infections with three being			 Corrective Action: R40 an R2, nursing staff educat Infection Control Program/Policy in regards to completing the resolution UTI s. St. Mark s Nursing staff and Nur Managers educated on Infection Co Program/Policy for antibiotic use and charting for resolution of signs and symptoms. Corrective Action as it applies other Residents:	n of rse ontrol d s to gram ed for	

Facility ID: 00394

If continuation sheet Page 2 of 4

PRINTED: 01/31/2017

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
				NG	1	7
		245369	B. WING _			19/2017
	PROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIF 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{F 441}	had resolved. R40's progress not administration reco 12/29/16 that R40 f On 1/6/17 note R40 changed due to see millimeters of dark sediment. Note dat urine output for 16 change, had been s Returned with diaguinfection) new orde mg twice daily for fi R40 had temperatu Fahrenheit, urine of 3:30 p.m. blood cor ER at 4:45 p.m. and increase fluids. Ret dehydration and UT Completion of antib record failed to hav of UTI after the con R2's progress notes administration reco 12/29/16, R2 had b urinary catheter cha of Ciprofloxacin 500 Note dated 12/30/1 left sided weakness dated 12/31/16, R2 stroke and UTI. Giv 600 milligrams in th 300 mg twice daily	ey infection/UTI. e date and resolution the UTIs es and medication rd (MAR) identified on nad not felt well, had emesis. D's catheter needed to be diment in tubing, additional 300 urine output noted thick ed 1/7/17 included R40 had no hours after a second catheter sent to emergency room (ER). nosis of pyelonephritis (kidney r for Bactrim DS 800 mg/160 ve days. Note dated 1/8/17 ure of 101.2 degrees utput 75 milliliters by 2 p.m., at ming from tip of penis, sent to d received an order to urn from ER with diagnosis of FI continue with antibiotic. piotic was 1/12/17. R40's e documentation of resolution npletion of the antibiotic.	{F 44 ⁻	 1) completed the course of a residents at POC meeting 2017 B. All Nursing staff will be charting following the use and signs and symptoms C. In PCC an area has be reminder for nurses to cha antibiotic use for residents 3. Date of Completion: 2017 4. Reoccurrence will by: A. Nursing staff education Changes Policy at POC m 31st, 2017 B. Audits will be complete results discussed at week Management meetings 5. Correction will be A. Staff Develope Control RN and DON B. QAPI committee will requarterly basis and will prodirection if needed. 	 January 31st, educated on of antibiotic use resolved. een added for art on follow up s. February 8th, be prevented n on Acute neeting, January, d monthly and ly Risk monitored by: er/Infection eview audits on a 	

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	01/31/2017 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		245369	B. WING				ך 19∕2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	I			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	continued with both and cednifir. Compl on 1/7/17. However resolution of the UT antibiotic. On 1/19/17 at 2:36 stated she was resp control (IC) program been working on the "straightened out" s 11/17/16). RN-B st need to document the symptoms after the for UTIs. RN-B veri been documented f On 1/19/17 at 4:51 she expected staff which includes mor determine if antibio completion of antibio resolution of UTIs. The facility policy In dated 2/16, indicate Procedure: Docume occurs at least daily of symptoms until 4	Coli. The MAR reads antibiotics of ciprofloxacin letion of Antibiotic regime was r, R2's record failed to have 'I after completion of the two p.m., registered nurse (RN)-B consible for the infection n. RN-B stated that she has e program and trying to get it since last survey visit (exit on ated they had included the he resolution of signs and completion of the antibiotic fied resolution of UTIs had not for either R40 or R2. p.m. Director of Nursing said to follow the infection policy, hitoring of resident to tic was affective and on totic use to document And if no resolution to notify	{F 4	41}			

Facility ID: 00394

If continuation sheet Page 4 of 4

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REV	/ISIT
	B. Wing	Y2	1/19/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWEST		
		AUSTIN, MN 55912		

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

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0157	Correction	ID Prefix F0309	Correction	ID Prefix	F0356 Correction
483.10(b)(11)	Completed	Reg. # 483.25	Completed	Reg. #	483.30(e) Completed
LSC	12/27/2016	LSC	12/27/2016	LSC	01/19/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
	GPN/kfd	1/25/2017		31221	1/19/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 11/17/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVIS	SIT Y3
NAME OF FACILITY ST MARKS LUTHERAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST		
		AUSTIN, MN 55912		

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

ITEM	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC K0372	12/22/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TL/kfd	DATE	SIGNATURE OF SURVEYOR		DATE	
		1/20/2017		37008		/19/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVE	Y COMPLETED ON		R ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567			5 🔲 NO



Protecting, maintaining and improving the health of all Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on February 16, 2017.

January 25, 2017

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

Re: Project # S5369026

Dear Mr. Finger:

On January 19, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 17, 2016 with orders received by you electronically on .

State licensing orders issued pursuant to the last survey completed on and found corrected at the time of this January 19, 2017 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on , found not corrected at the time of this January 19, 2017 revisit and subject to penalty assessment are as follows:

• 1375 -- MN Rule 4658.0800 Subp. 1 -- Infection Control; Program \$250.00

The details of the violations noted at the time of this revisit completed on January 19, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$250.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing

St Marks Lutheran Home January 25, 2017 Page 2

and Certification Program, Health Regulation Division, 18 Wood Lake Dr Se Rochester, Mn 55904.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

STATEMEN	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED
		00004	B. WING		R
		00394			1/19/2017
	PROVIDER OR SUPPLIER	400 - 15TI		STATE, ZIP CODE	
ST MARI	KS LUTHERAN HOM	F	MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
{2 000}	Initial Comments		{2 000}		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the define herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN R When a rule conta comply with any of lack of compliance re-inspection with a result in the assess	 Minnesota Statute, section ection order has been issued ey. If, upon reinspection, it is ciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of bartment of Health. whether a violation has been compliance with all e rule provided at the tag ule number indicated below. ins several items, failure to the items will be considered a. Lack of compliance upon any item of multi-part rule will sment of a fine even if the item 			
	that may result from orders provided the the Department wi	hearing on any assessments m non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.			
	signature is not rec page of state form is required, it is rec acknowledge rece	lled in ePOC and therefore a quired at the bottom of the first . Although no plan of correction quired that the facility ipt of the electronic documents.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursin Homes.	
	-	o visit was completed on			
	epartment of Health Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE
	i ally Cigned				01/01/

Electronically Signed

01/31/17

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				·	R	
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AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
T MARI	KS LUTHERAN HOME	-	HAVENUES MN 55912	SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
{2 000}	Continued From pa	ge 1	{2 000}			
	determined not all l corrected as found corrected licensing CMS2567B. These remain in effect and onsite visit.	During this onsite visit it was icensing orders were on this State Form along with orders found on the uncorrected order/s will d will be reviewed at the next rder/s will be reviewed for sessment/s.		The assigned tag number apper far left column entitled "ID Pref The state statute/rule out of cor listed in the "Summary Stateme Deficiencies" column and replay Comply" portion of the correction This column also includes the fi which are in violation of the state after the statement, "This Rule as evidence by." Following the st findings are the Suggested Met Correction and Time period for PLEASE DISREGARD THE HE THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ONI WILL APPEAR ON EACH PAG THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	ix Tag." npliance is nt of ces the "To n order. ndings e statute is not met surveyors hod of Correction. ADING OF CH OF S TO _Y. THIS E. TO TION FOR	
{21375}	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	{21375}			1/26/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by:	ent is not met as evidenced				
	Uncorrected based	on the following findings:		 Corrective Action: R40 an R2, nursing staff ec 	ucated on	
	Based on interview	and record review, the facility		Infection Control Program/Polic		

STATE FORM

Minnesc	ota Department of He					PPROVE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00394	B. WING		R 01/19	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	KS LUTHERAN HOME	-		SOUTHWEST		
		AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
{21375}	Continued From pa	ige 2	{21375}			
	program/policy in re resolution for Urina of 4 residents (R40 experienced UTIs. Findings included: The facility's Month	lize their infection control egards to completing the ry Tract Infections (UTIs) for 2 and R2) reviewed who ly Infection Control Reports on Logs were requested and		regards to completing the resolu UTI's. B. St. Mark's Nursing staff and N Managers educated on Infection Program/Policy for antibiotic use charting for resolution of signs an symptoms. 2. Corrective Action as it app other Residents:	lurse Control and nd	
	provided on 1/19/13 logs. The following 12/2016 there were UTIs 1/2017 there were UTIs and one kidne The logs lacked the had resolved.	7 from 12/2016 and 1/2017 was included on these logs: a 3 infections with two being 6 infections with three being by infection/UTI. a date and resolution the UTIs		 A. Will review Infection Control F related to antibiotic use and the related to antibiotic use and the related to completed the course of antibiotic residents at POC meeting, Janua 2017 B. All Nursing staff will be educated charting following the use of antibiand signs and symptoms resolved C. In PCC an area has been address of the symptome of th	need for has cs for all ary 31st, ted on biotic use ed. ded for	
	12/29/16 that R40 H On 1/6/17 note R40 changed due to see millimeters of dark sediment. Note dat urine output for 16 change, had been s Returned with diaguinfection) new orde mg twice daily for fi R40 had temperatu Fahrenheit, urine o 3:30 p.m. blood cor ER at 4:45 p.m. and increase fluids. Ret dehydration and UT Completion of antib	es and medication rd (MAR) identified on nad not felt well, had emesis. D's catheter needed to be diment in tubing, additional 300 urine output noted thick ed 1/7/17 included R40 had no hours after a second catheter sent to emergency room (ER). nosis of pyelonephritis (kidney r for Bactrim DS 800 mg/160 ve days. Note dated 1/8/17 ire of 101.2 degrees utput 75 milliliters by 2 p.m., at ming from tip of penis, sent to d received an order to urn from ER with diagnosis of TI continue with antibiotic. piotic was 1/12/17. R40's e documentation of resolution		 reminder for nurses to chart on fantibiotic use for residents. 3. Date of Completion: Januar 2017 4. Reoccurrence will be pre A. Nursing staff education on Ac Changes Policy at POC meeting 31st, 2017 B. Audits will be completed mont results discussed at weekly Risk Management meetings 5. Correction will be monito A. Staff Developer/Infect Control RN and DON B. QAPI committee will review a quarterly basis and will provide for direction if needed. 	ry 26th, vented by: tute , January, hly and red by: tion udits on a	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{21375}	Continued From pa of UTI after the con	ge 3 npletion of the antibiotic.	{21375}				
	12/29/16, R2 had b urinary catheter cha of Ciprofloxacin 500 Note dated 12/30/1 left sided weakness dated 12/31/16, R2 stroke and UTI. Giv 600 milligrams in th 300 mg twice daily 1/4/17 included the culture results of E. continued with both and cednifir. Comp on 1/7/17. However	s and medication rd (MAR) identified on een sent to Urology for a ange, order to start three days 0 mg twice daily for three days 6 R2 had been sent to ER for s and difficult to arouse. Note returned with diagnosis of ven dose of Cednifir (antibiotic) he ER and to continue dose of for seven days. Note dated lab called facility and R2 had coli. The MAR reads a antibiotics of ciprofloxacin letion of Antibiotic regime was r, R2's record failed to have TI after completion of the two					
	stated she was responsed out of (IC) program been working on the "straightened out" straightened out" straightened out of the straightened to document the symptoms after the for UTIs. RN-B veri	p.m., registered nurse (RN)-B ponsible for the infection n. RN-B stated that she has e program and trying to get it since last survey visit (exit on ated they had included the the resolution of signs and completion of the antibiotic fied resolution of UTIs had not for either R40 or R2.					
	she expected staff which includes mor determine if antibio completion of antib	p.m. Director of Nursing said to follow the infection policy, nitoring of resident to tic was affective and on iotic use to document And if no resolution to notify					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:	·····			
		00394	B. WING			R 01/19/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ST MAR	KS LUTHERAN HOM		TH AVENUE SC MN 55912	DUTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{21375}	Continued From pa	age 4	{21375}		51)		
	dated 2/16, indicate Procedure: Docum occurs at least dail of symptoms until until 48 hours after This uncorrected o will be reviewed at	entation in the clinical record y in the presence or absence 48 hours after the symptoms of the last dose of antibiotics. rder will remain in effect and the next onsite visit. Also this will be reviewed for possible	r				

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building			1	
00394 _{Y1}	B. Wing	Y	(2	1/19/2017	Y3
NAME OF FACILITY	•	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWEST			
		AUSTIN, MN 55912			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix 20265	Correction	ID Prefix 2083	0	Correction	ID Prefix	21426	Correction
MN Rule 4658 Reg. #	3.0085 Completed	Reg. # MN R Subp.	Rule 4658.0520 . 1	Completed	Reg. #	MN St. Statute 144A. Subd. 3	04 Completed
LSC	12/27/2016	LSC		12/27/2016	LSC		01/19/2017
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #		Completed	Reg. #		Completed
LSC		LSC			LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF S	URVEYOR		DA	TE
	GPN/kfd	1/25/2017			31221		19/2017
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOWUP TO SURV 11/17/2016	EY COMPLETED ON		DR ANY UNCORRECT	-			YES 🗌 NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 5S8S
	PART I -	TO BE COMP	PLETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 00394
1. MEDICARE/MEDICAID PROVIDE NO.(L1) 245369	R	3. NAME AND A (L3) ST MARKS	S LUTHERAN	HOME		 TYPE OF ACTION: <u>2</u>(L8) Initial 2. Recertification
2. STATE VENDOR OR MEDICAID N (L2) 055842700	NO.	(L4) 400 - 15TH (L5) AUSTIN, N		JTHWEST	(L6) 55912	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 11/17 8. ACCREDITATION STATUS:	/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF 11 ICF/III	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_ ` ´	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILIT	Y IS CERTIFIED	AS:		
From (a):		A. In Compl	iance With		And/Or Approved Waivers Of J	
To (b):		Complian	Requirements ce Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	61 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SN	F)8. Patient Room Size
13.Total Certified Beds	61 (L17)	X B. Not in Co	ompliance with Pro	gram	5. Life Safety Code	9. Beds/Room
		Requirement	ts and/or Applied	Waivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
61						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA			DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kyla Einertson, HFE N	EII		12/16/2016	(L19)	Kamala Fiske-Downing, E	inforcement Specialist 01/13/2017 (L20)
PAR	T II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE ST	FATE AGENCY
19. DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa			MPLIANCE WITI 3HTS ACT:	H CIVIL		1 Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	nicipate				3. Both of the Above	:
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT	24. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 12/01/1986	BEGINNINC	B DATE	ENDING DA	TE	VOLUNTARY0001-Merger, Closure	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	. ,		03-Risk of Involuntary Termination	n OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	Y/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATIO	N OF APPROVAI	DATE		
	(L32)			(L33)	DETERMINATION APPR	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 12, 2016

Mr. Murray Finger, Administrator St Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

RE: Project Number S5369026 and Complaint Number H5369059

Dear Mr. Finger:

On November 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the November 17, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5369059 that was found to be unsubstantiated.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 <u>Email: gary.nederhoff@state.mn.us</u> Telephone: (507) 206-2731 Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or LSC survey or deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles). The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. Your facility meets the criterion and remedies will be imposed immediately pursuant to a survey completed on November 17, 2016. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 17, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309, effective November 17, 2016 (42 CFR 488.430 through 488.444).
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 17, 2017. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St. Marks Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation

Programs for two years effective February 17, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 February 17, 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 May 17, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit St Marks Lutheran Home December 12, 2016 Page 6 Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245369	B. WING			11/	17/2016
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST MAR	(S LUTHERAN HOME	E			00 - 15TH AVENUE SOUTHWEST IUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000			
F 157 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has been your verification sur complaint investigat time of the standard An investigation of completed. The co 483.10(b)(11) NOT (INJURY/DECLINE A facility must immed consult with the rest known, notify the rest or an interested fan accident involving t injury and has the p intervention; a sign physical, mental, or deterioration in heat status in either life t clinical complication significantly (i.e., a existing form of treat	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with vey was conducted and a tion was also completed at the d survey. complaint H5369059 was mplaint was not substantiated. IFY OF CHANGES	F 1	57			12/27/16
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/13/2016

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.

PRINTED: 12/14/2016

	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MEILT	IPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		VG	· · /	PLETED
		245369	B. WING _		11/	17/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
ST MAR	KS LUTHERAN HOMI	E		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	the resident from th §483.12(a). The facility must al and, if known, the r or interested family change in room or specified in §483.1 resident rights under regulations as spec this section. The facility must re the address and ph	age 1 cision to transfer or discharge he facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's e or interested family member.	F 1	57		
	by: Based on interview facility failed to ens of a decline in heal congestive heart fa hospitalization for 1 death record was r Findings include: R99 was admitted 10/12/16, from a lo including: weaknes kidney injury, and h bleed. R99's admis dated 10/19/16, ide cognition and was R99's care plan da problem areas rela	NT is not met as evidenced v and document review, the ure the physician was notified th status in regards to illure and weight gain following I of 1 resident (R99) whose eviewed. to the nursing facility on ocal hospital with diagnoses is, dehydration, acute/chronic history of a gastrointestinal soin Minimum Data Set (MDS) entified R99 had intact able to verbalize her needs. ted 10/12/16, indicated ted to altered cardiovascular estive heart failure, peripheral		 Corrective Action: Resident R 99, Staff educ change of Acute Condition Poper proper steps taken to inform p family and resident St. Mark S Living will notif individuals necessary if there change or roommate assignn St. Mark Living will period update resident contact inf and legal representatives Corrective Action as it other Residents:	licy and ohysician, y the is a room nent odically ormation applies to changes c meeting	

Facility ID: 00394

If continuation sheet Page 2 of 21

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		SURVEY PLETED	
		245369	B. WING	G		11/17/2016		
NAME OF	PROVIDER OR SUPPLIER		· [ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LUTHERAN HOM	E		00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE	
F 157	pedal edema, vital (medical doctor) of monitor and docum lung sounds on aus in weight, monitor a symptoms of coron chest pain, pressur changes in capillary extremities. R99's admission or an order for torsem for weight gain grea 24 hours, or a 1 lb three days, or peda also ordered contin cannula 1 liter, to k greater than 90%. Although R99 had I admission weight w and was document section of the elect On 10/31/16 the ne pounds a 12 pound been reported to th practitioner (NP)-A on 11/1/16 with a lo not reported to the assessment compli- taken on 11/2/16 ar and increase of 0.8 no respiratory asset the physician notifie A nurse's note doct	age 2 ded: Daily weights, monitor signs weekly, notify MD significant abnormalities, nent as needed changes in scultation, edema and changes and document for signs and hary artery disease including- re, nausea, dependent edema, y refill, and color/warmth of rders dated 10/12/16, included hide 10 mg (diuretic) by mouth ater than three pounds (lb) in weight gain for greater than al edema. The physician had huous oxygen via nasal eep O2 (oxygen) saturations been admitted on 10/12/16, an vas first recorded on 10/20/16, ed as 95.9 lbs in the weight ronic medical records (EMR). ext weight was recorded at 108 d gain. This weight gain had not e physician or the nurse . The third weight was taken oss of 3 pounds. Again this was physician nor a respiratory eted. The fourth weight was nd recorded as 105.8 pounds a pounds and again there was ressment completed nor was ed of the weight gain. umented in the EMR 10/31/16, ge had been sent to the nurse	F 1	57	or roommates C. Staff responsible for periodic upda of resident information will be educat 3. Date of Completion: Decemb 27th, 2016 4. Reoccurrence will be prevent by: A. Nursing staff education on Acute Changes Policy at POC meeting December 20th, 2016 B. Audits will be completed monthly a results discussed at weekly risk Management meetings C. Staff will inform resident and individual of necessary to the residen any changes in room or roommates 5. Correction will be monitored to A. DON or designee B. QAPI committee will review audite quarterly basis and will provide furthed direction if needed	ted ber ted and nt of by: cs on a		

If continuation sheet Page 3 of 21

		AND HUMAN SERVICES			FORM	: 12/14/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245369	B. WING		11/	17/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	:		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	inspiratory wheezes sounds, and three p did not indicate the R99's weight gain (the next recorded w lb). A faxed respons received by the faci appreciated the upo continue to keep he On 11/1/16, an inter meeting note identifi have 3+ edema in h weekend, had a 10 utilized the torsemic indicated the occup hold the lymphedem overload was back indication the physic notified of the weigh The electronic med identified R99 had r consecutive days o 11/2/16 due to weig indication the facility pulmonary status as had they updated th pound weight gain a torsemide. Further record revise experienced an incr notes documented R99 was yelling out staff, and was very indicated as long as room, she was calm	s, lower lobe diminished breath olus pitting edema. The note NP-A had been informed of 10/20/16 weight 95.9 lb and weight dated 10/31/16 was 108 se from the NP-A had been ility on 10/31/16, indicating she date and wanted staff to er updated on R99's condition. rdisciplinary team (IDT) fied R99 had been noted to her lower extremities over the lb weight gain, and had de. The IDT note also wational therapist was going to na treatment until her fluid in line. There was no cian or the NP-A had been	F 15	7		

Facility ID: 00394

If continuation sheet Page 4 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245369	B. WING			11/17/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST MAR	KS LUTHERAN HOME	:			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	indicated the reside up phlegm" and ind staff had seen an "i behaviors." Again t physician or the NP increase in anxiety, hunger. An entry in the EMF indicated R99 had t and was upset. The had stated she coul believe me." Accord the Chaplain, and the the resident and tries indicated: "Residen and stated that he w today" and indicated had been checked increased the oxyge Again no timely not NP-A in regards to NP-A in regards to Another EMR entry indicated: "[family n verbal ok over the p ER (emergency roo 7:03 p.m. on 11/2/1 EMR that indicated from the local hosp Rochester due requ due to pulmonary e was reviewed furthe documentation four contacted the physi gain, anxiety, breatl status. Instead, the	ge 4 Int stated she was "coughing icated this was the first time ncrease in anxiety and here was no indication the -A had been updated as to the behaviors indication oxygen A dated 11/2/16 at 1:57 p.m., been speaking to the chaplain e note indicated the resident Id not breathe and "they don't ding to the EMR note, an aide, ne social worker talked with ed to comfort her. The note t was asking for her doctor vas going to come again d the resident's oxygen levels and the nursing assistant had en at the nurse's request. dication of the physician or having difficulty breathing. from 2:02 p.m. 11/2/16, nember's name (FM-A)] gave obone to transfer resident to om) for eval and treatment." At 6, there was an entry in the R99 had been transferred ital to St. Mary's Hospital in uiring a higher level of care dema. The resident's record er, and there was no nd to indicate the facility had cian regarding R99's weight hing difficulty and pulmonary facility staff had contacted the mission to send R99 to the	F -	157			

If continuation sheet Page 5 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL		MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245369	B. WING _			11/-	17/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	1			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 157	Continued From pa	ge 5	F 1	57			
		R dated 11/7/16, indicated ne nursing home that R99 died					
	(RN-M) manager or stated she had bee trouble breathing, h extremity edema. R R99 and had subse the licensed practic family for permissio emergency room. V notified the physicia she had not contact because it could ha them to call back."	with the registered nurse in 11/16/16 at 2:43 p.m., RN-M in aware R99 was having ad anxiety and had lower N-M stated she had assessed equently provided direction to cal nurse (LPN) to call the in to transfer R99 to the When asked whether she had an prior to transfer, RN-M said ted the resident's physician ve taken a "day and a half for Review of the EMR failed to ented assessment of R99's er being sent to the hospital.					
	worker (LSW) was recalled having bee unknown nursing as The LSW stated RS weekend before ho documentation of a The LSW stated RS	1 p.m., the licensed social interviewed. The LSW on in R99's room with an ssistant (NA) and the chaplain. 29 had been hallucinating the wever, there was no ny hallucinations in the EMR. 29 had been very scared and thought had caused R99 to eath.					
	director of nursing (been weighed daily admission weight w within the first 24 ho	on 11/16/16 at 3:32 p.m., the DON) stated R99 should have and the expectation for an vas that it would be obtained ours from admission. The lack of weights had been					

If continuation sheet Page 6 of 21

PRINTED: 12/14/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 12/14/2016 APPROVED . 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245369	B. WING		11/	11/17/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ST MARI	KS LUTHERAN HOME	1	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 157	Continued From pa	ge 6	F1	57				
F 309 SS=G	change and was no An undated policy, The policy did not a process for obtainin 483.25 PROVIDE O HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	for "weights" was reviewed. ddress the nursing facility's ng weights. CARE/SERVICES FOR	F 3	09		12/27/16		
	by: Based on interview facility failed to ade interventions to trea resident (R99) who The facility's failure assessment and im R99 who suffered a requiring subseque Findings include: R99 was admitted to 10/12/16, from a lo including: weaknes kidney injury, and h bleed. R99's admis dated 10/19/16, ide cognition and was a	NT is not met as evidenced y and document review, the quately assess and implement at fluid retention for 1 of 1 se death record was reviewed. to provide adequate tervention resulted in harm for anxiety and difficulty breathing nt hospitalization. o the nursing facility on local hospital with diagnoses s, dehydration, acute/chronic istory of a gastrointestinal sion Minimum Data Set (MDS) ntified R99 had intact able to verbalize her needs. ed 10/12/16, indicated		 Corrective Action: Resident R 99, staff educate Change of Acute Condition Poli proper steps taken to inform ph family and resident Nursing staff and Nurse Man educated on change of Acute C Changes- clinical protocol Corrective Action as it ap other Residents: A. Will review Acute changes P residents at POC meeting Dece 20th, 2016 All Nursing staff educated on s needed to inform those necessi 	cy and ysician, agers ondition oplies to olicy for all ember ated on er policy steps			

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-	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	PLETED		
		245369	B. WING		11/	17/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,				
ST MAR	KS LUTHERAN HOM	E		400 - 15TH AVENUE SOUTHWI AUSTIN, MN 55912	EST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE		
F 309	Continued From pa	age 7	F 30	9				
		ted to altered cardiovascular		individuals				
	vascular disease a Interventions includ	estive heart failure, peripheral nd oxygen dependence. ded: Daily weights, monitor		2. Date of Completion 2016	a: December 27th,			
	 pedal edema, vital signs weekly, notify medical doctor of significant abnormalities, monitor and document as needed changes in lung sounds on auscultation, edema, changes in weight, monitor and document for signs and symptoms of coronary artery disease including- chest pain, pressure, nausea, dependent edema, changes in capillary refill, and change in color/warmth of extremities. R99's admission orders dated 10/12/16, included an order for torsemide 10 mg (diuretic) by mouth for weight gain greater than three pounds (lb) in 24 hours, or a 1 lb weight gain for greater than 			4. Reoccurrence v by: A. Nursing staff educat Changes Policy at POC December 20th, 2016 B. Audits will be completer results discussed at we Management meetings 5. Correction will be A. DON or des B. QAPI committee will quarterly basis and will	tion on Acute C meeting eted monthly and eekly risk be monitored by: signee I review audits on a			
	three days, or peda also ordered contir cannula 1 liter, to k greater than 90 per Although R99 had 10/12/16, the first v 10/20/16 (eight day documented as 95	al edema. The physician had nuous oxygen via nasal seep oxygen (O2) saturations		direction if needed				
	While the admission included on R99's of included weights sl were only three add after 10/20/16: 10/31/16: 108 lbs. 11/1/16: 105 lbs. 11/2/16 105.8 lbs A nursing progress	on orders from the hospital and comprehensive care plan hould be monitored daily, there ditional weights documented						

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		AND HUMAN SERVICES				FORM	12/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING			11/ [.]	17/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	1			00 - 15TH AVENUE SOUTHWEST NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	for rehabilitation, ar therapy services. Th with activities of dai deconditioning which therapy. The progree documented conce breathing, pulmonal edema. A nurse's note docu 10/31/16, indicated the nurse practition regarding R99's hav lower lobe diminish- plus pitting edema. NP-A had been info 12 pounds from 10/ 10/31/16 was 108 lk NP-A had been rece 10/31/16, indicating and wanted staff to on R99's condition. On 11/1/16, an inter meeting note identifi have 3+ edema in h weekend, had a 10 utilized the torsemic also indicated the o going to hold the lyr fluid overload was b The electronic med identified R99 had r consecutive days o 11/2/16 due to weig no indication the fac pulmonary status (b health assessment	nd continued to receive he note identified limitation ily living, ambulation and ch required rest periods for ess noted did not include any rns related to the resident's any status, weight gain or umented in the EMR dated a message had been sent to er (NP)-A at the local clinic, ving inspiratory wheezes, ed breath sounds, and three The note did not indicate the ormed of R99's weight gain of /20/16 weight 95.9 lb and on b. A faxed response from the eived by the facility on g she appreciated the update continue to keep her updated rdisciplinary team (IDT) fied R99 had been noted to her lower extremities over the lb weight gain, and had de (diuretic). The IDT note occupational therapist was mphedema treatment until her	F3	809			

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		AND HUMAN SERVICES				FORM	12/14/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING	i		11/17/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	Ξ			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	updated the physici pound weight gain a torsemide. Further record revise experienced an incl Nursing notes docu indicated R99 was out at staff, and was indicated as long as room, she was caln leave her room she note indicated the r "coughing up phleg first time staff had s and behaviors." An entry in the EMF indicated R99 had b and was upset. The the resident had sta "they don't believe r note, an aide, the C worker talked with t comfort her. The no asking for her docto going to come agai resident's oxygen le the nursing assistan level at the nurse's Another EMR entry indicated: "[family n ok over the phone t [emergency room] f 11/2/16 at 7:03 p.m EMR that indicated from the local hosp	ian/NP-A about R99's 10 and subsequent use of ew indicated R99 had rease in anxiety behaviors. umented 11/2/16 at 1:05 p.m. yelling out, attempting to strike s very demanding. The note s staff remained in R99's n but when staff started to e would yell out for help. The resident stated she was ym" and indicated this was the seen an "increase in anxiety R dated 11/2/16 at 1:57 p.m., been speaking to the chaplain e note indicated during the visit ated she could not breathe and me." According to the EMR Chaplain, and the facility social the resident and tried to obte indicated: "Resident was or and stated that he was in today" and indicated the evels had been checked and nt had increased the oxygen	F	309			

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		AND HUMAN SERVICES				FORM	12/14/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245369	B. WING			11/	17/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
ST MAR	KS LUTHERAN HOME	<u>.</u>			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	due to pulmonary e was reviewed furthe documentation four contacted the physi gain, increased anx decline in pulmonar was an admission of facility staff had cor permission to send An entry in the EMF FM-A had notified th on 11/6/16. During an interview (RN)-M a manager RN-M stated she ha having trouble brea lower extremity ede assessed R99 and direction to the lice call the family for pe the emergency roon had notified the phy said she had not co physician because a half for them to ca failed to include any R99's condition pric hospital. During the interview 11/16/16, RN-M cor and verified a weigh until the 8th day afte was supposed to ha said when she had weighed per protoc	ge 10 dema. The resident's record er, and there was no nd to indicate the facility had ician regarding R99's weight kiety, breathing difficulty and ry status. Even though there order to do so. Instead, the ntacted the family to obtain R99 to the emergency room. A dated 11/7/16, indicated he nursing home that R99 died with the registered nurse on 11/16/16 at 2:43 p.m., ad been aware R99 was thing, had anxiety and had ema. RN-M stated she had had subsequently provided ensed practical nurse (LPN) to ermission to transfer R99 to m. When asked whether she visician prior to transfer, RN-M ontacted the resident's it could have taken a "day and all back." Review of the EMR y documented assessment of or to her being sent to the w with RN-M at 2:43 p.m. on nfirmed R99's admission date, nt had not been documented er admission even though R99 ave been weighed daily. RN-M realized R99 had not been ol, she said she immediately ift nursing staff because the	F	809				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245369	B. WING			11/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	E			00 - 15TH AVENUE SOUTHWEST NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	she was monitoring was documented w the nurses had rece On 11/16/16 at 3:30 left for the LPN to re with no return call. On 11/16/16 at 2:3 worker (LSW) was recalled having bee unknown nursing as The LSW stated RS weekend before ho documentation of a The LSW stated RS agitated which she become short of bro When interviewed of director of nursing (been weighed daily admission weight w within the first 24 ho DON confirmed the identified by RN-M had been provided been implemented. A request was mad change and was no An undated policy, The policy did not a process for obtainin 483.30(e) POSTED	n the day shift. RN-M stated this process. The education ith staff signatures to confirm eived training per the RNM. 0 p.m. a phone message was eturn a call for an interview 1 p.m., the licensed social interviewed. The LSW on in R99's room with an ssistant (NA) and the chaplain. 09 had been hallucinating the wever, there was no ny hallucinations in the EMR. 09 had been very scared and thought had caused R99 to eath. 00 11/16/16 at 3:32 p.m., the DON) stated R99 should have and the expectation for an vas that it would be obtained burs from admission. The lack of weights had been and as a result staff education and monitoring of weights had e for a policy related to status of provided. for "weights" was reviewed.	F 3		DEFICIENCY)		12/27/16
SS=C	INFORMATION						

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	MENT OF HEALTH		FORM	APPROVED			
		& MEDICAID SERVICES		TIDI			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING			11/1	17/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	E			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 356	Continued From pa	ae 12	F 3	56			
		st the following information on	10	00			
	a daily basis:						
	o Facility name.						
	o The current date.	and the actual hours worked					
	by the following cate	egories of licensed and					
		staff directly responsible for					
	resident care per sł - Registered nu						
		tical nurses or licensed					
		as defined under State law).					
	- Certified nurse o Resident census.						
	specified above on of each shift. Data o Clear and readab	ace readily accessible to					
	make nurse staffing	con oral or written request, data available to the public not to exceed the community					
	The facility must ma	aintain the posted daily nurse					
		ninimum of 18 months, or as w, whichever is greater.					
	This REQUIREMEN	NT is not met as evidenced					
	Based on observat review the facility fa	ion, interview and document iled to consistently include			 Corrective Action: A. Facility will post accurate daily no 	ursing	
		ours worked on the daily			hours B. Full shifts and half shifts will be		
		g. This had the potential to its residing at the facility as rs.			included on daily census sheets for nursing hours	all	

Facility ID: 00394

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	12/14/2016 APPROVED 0938-0391			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED			
		245369	B. WING _	11/1	7/2016			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ST MAR	(S LUTHERAN HOME			400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 356	Continued From pa	ge 13	F 35	56				
	facility nursing hour correct actual hours registered nurse (R (LPN), trained med nursing assistance the nursing hours w Hours of shift poste 11/14/16- 1 NA shift a.m11:00 a.m. (5 shift-6:00 a.m2:00 posted for the shift p.m.(8 hours) vs. th shift-2:00 p.m8:00 11/15/16-1 NA shift p.m10:00 p.m. (8 hours 2:00 p.m8:00 11/16/16-1 NA shift p.m10:00 p.m. (8 hours 2:00 p.m8:00 shift posted for the	t posted for hours 6:00 hours) vs. actual hours of p.m. (8 hours); and 1 NA shift identified as 2:00 p.m10:00 e actual shift hours hours of p.m. (6 hours). posted for the hours 2:00 hours) vs. the actual shift		 Corrective Action as it applies to other Residents: A. St. Mark s Living will post accurate daily census sheets that will reflect actual hours worked by nursing staff Date of Completion: December 27th, 2016				
F 441 SS=F	director of nursing of confirmed the facilit had inaccurate act worked each day as 483.65 INFECTION SPREAD, LINENS	acility staffing scheduler and on 11/17/16, at 12:00 p.m. y daily nursing hour posting ual nursing hours/shifts s listed above. I CONTROL, PREVENT tablish and maintain an	F 44	11	12/27/16			

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	LE CONSTRUCTION	1	0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245369	B. WING			44/-	17/0016
NAME OF F	PROVIDER OR SUPPLIER	240000			TREET ADDRESS, CITY, STATE, ZIP CODE		17/2016
		_			00 - 15TH AVENUE SOUTHWEST		
SIMAR	(S LUTHERAN HOME	-		A	AUSTIN, MN 55912		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 441	Continued From no	ao 14					
1 441	Continued From pa	ogram designed to provide a	F 4	41			
		comfortable environment and					
	to help prevent the	development and transmission					
	of disease and infe	ction.					
	(a) Infection Contro	l Program					
		tablish an Infection Control					
	Program under which	ch it - ntrols, and prevents infections					
	in the facility;	nicols, and prevents infections					
	(2) Decides what pr	rocedures, such as isolation,					
		o an individual resident; and					
	actions related to in	ord of incidents and corrective infections.					
	(b) Preventing Spre	ad of Infection ion Control Program					
		esident needs isolation to					
	prevent the spread	of infection, the facility must					
	isolate the resident.						
		t prohibit employees with a ase or infected skin lesions					
	from direct contact	with residents or their food, if					
	direct contact will tr						
		t require staff to wash their rect resident contact for which					
	hand washing is inc						
	professional practic	e.					
	(c) Linens						
		ndle, store, process and					
	transport linens so	as to prevent the spread of					
	infection.						
		<u> </u>					
		NT is not met as evidenced					
	by: Based on interview	and record review the facility			1. Corrective Action:		

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	ST CONTRECTION	DENTIFICATION NOMBER.	A. BUILDI	ING		00101	
		245369	B. WING			11/1	7/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	E			00 - 15TH AVENUE SOUTHWEST NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 15	F4	41			
	failed to maintain a that tracked and an trends, failed to ide infections (UTI's), and document reso residents (R11, R7- who experienced U Findings included: Tracking and Analy The facility's Month and Monthly Infecti 1/16 through 10/16 identified the follow -1/16: 6 infections (-2/16: 4 UTI's; -3/16: 8 infections (-4/16: 3 infections (-5/16: 8 infections (-5/16: 8 infections (-6/16: No reports o -7/16: 7 infections (-8/16: 7 infections (-10/16: 11 infection The records lacked infections for the m identification wheth and/or community a consistent docume symptoms, culture The facility provided	n infection control program halyzed infection patterns and entify recurrent urinary tract failed to obtain culture results olution for UTI's for 5 of 5 4, R43, R36, R22) reviewed ITI's. (A Were UTI's); (A Were UTI's); (A Were UTI's); (A Were UTI's); (A Were UTI's). (A Were UTI's). (A Were UTI's). (A the following: tracking of ionth of June 2016, ier the infections were in house acquired, date resolved and ntation of signs and results and date onset. (A the following information:			 A. St. Mark□s Living will establish Infection Control Program which will Investigate, control and prevent infections in the facility Decides which isolation should applied to an individual resident Maintains a record of incidents corrective actions related to infection B. St. Mark□s Living will Prevent th spread of infections by: Determining the proper need for isolation to prevent the spread of inf Prohibit employees with communicable disease or infected s lesions from direct contact with resid and their food if direct contact will sp the disease St. Marks□s will require that employees wash their hands after d contact with residents Laundry must handle, store and process and transport linens so as t prevent the spread of infection. 2. Corrective Action as it applies other Residents: A. St. Mark□s will establish an infection control program for all residents tha prevents the spread of infections as stated above B. Nursing staff and environmental si will be educated on infection control program at POC meeting December 2016 2. Date of Completion: December 	I: be and ns he r fection skin dents oread irect i. o s to tion t staff r 20th,	
	The records lacked infections for the m identification wheth and/or community a consistent docume symptoms, culture The facility provide nursing assistant m education of UTI's	I the following: tracking of onth of June 2016, her the infections were in house acquired, date resolved and ntation of signs and results and date onset.			control program for all residents tha prevents the spread of infections as stated above B. Nursing staff and environmental s will be educated on infection control program at POC meeting Decembe 2016	t staff r 20th, ^r 27th,	

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TATEMEN	F OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245369	B. WING		11/	17/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST MAR	KS LUTHERAN HOME	1		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 441	8/24/16, included in hand hygiene and g meeting 8/24/16, in hand hygiene and g In addition, the reco analysis of infection identification of outl implementing and g related problems. UTI Monitoring (Cu R11's progress note administration reco following: -7/28/16, complains complains back pai urination and foul s emergency departn diagnosis of UTI. G Levaquin (antibiotic (milligrams) daily fo call to change antib more effective on c dated 7/16 and 8/16 received Levaquin 8 8/1/16 and Cefdinir days, starting 8/2/10 include culture resu resolution of the UT -10/24/16, sent to E reactions. Returned UTI. 10/25/16, Cefc times seven days. Temp 99.3. 10/27/1 UTI. Temp 96.3. No discomfort. R11's M R11 received Cefdi	fection control issue, UTI's, glove use. Nursing assistant cluded infection control issues glove use. ords failed to include an as, which included breaks of infection as well as documenting actions to resolve lture Results and Resolution) es and medication rd (MAR) identified the s vaginal pain. 7/30/16 n, intense burning with melling urine. 7/30/16, to nent (ED) and returned with iven dose IV (intravenous)). Order for Levaquin 500 mg r five days. 8/1/16, received iotic to Cefdiner due to being urrent infection. R11's MAR 6 identified the resident 500 mg daily on 7/31/16, 300 mg twice daily for 10 6. R11 ' s record failed to ilts and documentation of	F 4	 A. Nursing staff and environm will be educated on Infection coprogram at POC meeting Dece 20th,2016 B. Records will indicate tracking infections acquired by in house analysis of infections C. Audits will be completed more results discussed at QAPI. 5. Correction will be monite A. DON or designee B. QAPI committee will review quarterly basis and will provide direction if needed 	ntrol mber as well as nthly and pred by: audits on a	

If continuation sheet Page 17 of 21

		AND HUMAN SERVICES				FORM	12/14/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING	i		11/ [.]	17/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST MAR	KS LUTHERAN HOME	<u>=</u>			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	results and docume UTI. R74's progress not administration reco following: -9/19/16 patient has the morning to resp ED. Returned from UTI, Cipro 250 mg R74's MAR dated 9 received Cipro 250 days. Documentatic culture results and resolution. R43's progress not administration reco following: -7/6/16, confused a needed to use the k orders for acquire u with results. Urine of evaluation. 7/7/16 u twice daily for 10 day when antibiotic is d once asking to void complaints of pain. daily for 10 days, co 8/2/16 fax stating u medications except expensive. Not able kidney function. Wi treatment. Physicia medication tomorro for 7 doses. R43's I received Cipro 250 The facility failed to	entation of resolution of the es and medication rd (MAR) identified the s not been herself, very slow in bond or eat. Order to send to the hospital, new orders for twice daily for seven days. 0/16 identified the resident mg two times a day for seven on in R74's record lacked documentation of UTI	F 4	441			

Facility ID: 00394

If continuation sheet Page 18 of 21

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP			(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			à		PLETED	
		245369	B. WING			11/ [.]	17/2016	
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>ı</u>		
ST MAR	KS LUTHERAN HOME	:			400 - 15TH AVENUE SOUTHWEST			
		•			AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	include culture resu treatment and docu UTI's for 7/6/16 and	Its for the 8/2/16 UTI Imentation of resolution of the d 8/2/16.	F 4	41				
	following: -9/2/16-combative w behaviors with son. be sent. Resident s sample. Resident e yelling out. There is orders for an antibio 9/3/16 Cephalexin 2 for UTI. R36's MAR received Cephalexi days. Documentati	es and MAR identified the with cares and having Hospice contacted, nurse will con request to obtain a urine extremely anxious, restless and a potential for a UTI and has otic to start in the morning. 250 mg 4 times/day for 7 days & dated 9/16 identified R36 n 250 mg four times daily for 7 ion in R36's record failed to ults and resolution of the UTI.						
	following: -6/27/16 resident set leaning to the left w upon observation levia stretcher. Nurse resident will be sem slight trace bacteria resident on Levaqu IV dose and returne 750 mg daily for 5 of Levaquin and start for 7 days. Review R22 received Levao R22's record failed documentation of re On 11/17/16, at 12: (RN)-C stated she w	es and MAR identified the een sitting in wheelchair with left arm hanging down, eft side facial droop, left facility e called emergency room, t back. They stated urine had a and were going to start in and they administered R22 ed with orders for Levaquin days. 7/1/16 discontinue Macrobid 100 mg twice daily of the June MAR identified quin and Macrobid as ordered. to include culture results and esolution of the UTI.						
		b) program, starting with ponitoring April 2016 and was						

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PRINTED: 12/14/2016

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 12/14/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245369	B. WING	ì		11/	17/2016
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	Ξ			400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	absent for the moni explained that durin nursing (DON) was monitoring. RN-C v did not include all re analysis of infection RN-C verified resol documented. The facility policy In Prevention Program facility develops, im Infection Prevention to prevent, recogniz possible, the onset the facility. Procedu designated to serve infection prevention nurse is considered Preventionist (IP). S with infection contro of the IP may includ Overseeing staff/vo control policies and annually and as neu- tracking of infection and reports for revi Committee; e) Colla to develop correctiva any errors, problem the infection contro Monitoring antibioties The facility policy In dated 2/16, indicate Policy: Signs and s continually monitore Purpose: To identify	ths of July and August. She ng her absence the director of a responsible for the IC verified tracking of infections equired information and ns had not been documented. lution of UTI's was not being infection Control and m, dated 5/11, indicated the nplements, maintains an n and Control Program in order ze, and control, to the extent and spread of infection within ure: 1) A registered nurse is e as coordinator of the n and control program. The d the facility's Infection Staff are assigned to assist ol program, as needed. Duties de but are not limited to: b) oblunteer training on infection d procedures upon hire, needed; d) Overseeing the ns, monthly infection reports, iew by the Quality Assurance aborates with QA Committee ve action plans to respond to ns or other identified issues in ol and prevention program. F) ic use.		441			

If continuation sheet Page 20 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTON (M) DENTIFICATION NUMBER: DENTIFICATION NUMBER: 245369 (M) MULTIPLE CONSTRUCTION A BUILDING			AND HUMAN SERVICES				FORM	: 12/14/2016 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST MARKS LUTHERAN HOME 400 - 15TH AVENUE SOUTHWEST Image: Summary statement of deficiencies ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID TAG (EACH OEFICIENCY MUST BE PRECOEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION (EACH OCRRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 441 Continued From page 20 put into place; to control outbreaks of infectious disease. F 441 F 441 Procedure: (1.) Daily: All residents are monitored for current signs/symptoms of infection and infection risk. Documentation ion the clinical record occurs at least daily in presence or absence of symptoms until 48 hours after the symptoms subside or until 48 hours after the symptoms on a monthly infection log. (2.) Monthly: the IP completes the monthly infection report. The report is forwarded to the director of nursing. The monthly report includes a Mate								
ST MARKS LUTHERAN HOME 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912 ^(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 (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) COMPLETION PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DATE F 441 Continued From page 20 put into place; to control outbreaks of infectious disease. Procedure: (1.) Daily: All residents are monitored for current signs/symptoms of infection and infection risk. Documentation ion the clinical record occurs at least daily in presence or absence of symptoms until 48 hours after the symptoms subside or until 48 hours after the last dose of antibiotics. The IP monitors the infection log frequently and records confirmed (meet criteria) infections on a monthly infection log. (2.) Monthly: the IP completes the monthly infection report. The report is forwarded to the director of nursing. The monthly report includes a			245369	B. WING		·····	11/	17/2016
ST MARKS LUTHERAN HOME AUSTIN, MN 55912 (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) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (AUSTIN) F 441 Continued From page 20 put into place; to control outbreaks of infectious disease. Procedure: (1.) Daily: All residents are monitored for current signs/symptoms of infection and infection risk. Documentation ion the clinical record occurs at least daily in presence or absence of symptoms until 48 hours after the symptoms subside or until 48 hours after the last dose of antibiotics. The IP monitors the infection log frequently and records confirmed (meet criteria) infections on a monthly infection log. (2.) Monthly: the IP completes the monthly infection report. The report is forwarded to the director of nursing. The monthly report includes a	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 441 Continued From page 20 put into place; to control outbreaks of infectious disease. F 441 F 441 F 441 Procedure: (1.) Daily: All residents are monitored for current signs/symptoms of infection and infection risk. Documentation ion the clinical record occurs at least daily in presence or absence of symptoms until 48 hours after the symptoms subside or until 48 hours after the last dose of antibiotics. The IP monitors the infection log frequently and records confirmed (meet criteria) infections on a monthly infection log. (2.) Monthly: the IP completes the monthly infection report. The report is forwarded to the director of nursing. The monthly report includes a Completion of the director of nursing. The monthly report includes a	ST MARK	(S LUTHERAN HOME	E					
put into place; to control outbreaks of infectious disease. Procedure: (1.) Daily: All residents are monitored for current signs/symptoms of infection and infection risk. Documentation ion the clinical record occurs at least daily in presence or absence of symptoms until 48 hours after the symptoms subside or until 48 hours after the last dose of antibiotics. The IP monitors the infection log frequently and records confirmed (meet criteria) infections on a monthly infection log. (2.) Monthly: the IP completes the monthly infection report. The report is forwarded to the director of nursing. The monthly report includes a	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
	F 441	put into place; to co disease. Procedure: (1.) Dai for current signs/sy infection risk. Docu record occurs at lea absence of sympto symptoms subside dose of antibiotics. log frequently and r criteria) infections of Monthly: the IP com report. The report is nursing. The month	ly: All residents are monitored mptoms of infection and mentation ion the clinical ast daily in presence or ms until 48 hours after the or until 48 hours after the last The IP monitors the infection records confirmed (meet on a monthly infection log. (2.) npletes the monthly infection s forwarded to the director of ally report includes a	F 4	.41	DEFICIENCY)		

Facility ID: 00394

If continuation sheet Page 21 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES			Fh31,9725	FORM	12/19/2016 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A, BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245369	B. WING	;		11/	17/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	(S LUTHERAN HOME				00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	rs	ĸ	000				
	FIRE SAFETY							
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.						
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
	Minnesota Departm Fire Marshal Divisio dated 11/17/16, St. found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),						
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			EPOC			
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145						
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	
Electron	ically Signed						12/13/2016	

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.

		AND HUMAN SERVICES				APPROVE
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
		245369	B. WING		11	/17/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 400 - 15TH AVENUE SOUTHWES AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
K 000	Continued From pa By email to: Marian.Whitney@s Angela.Kappenma	state.mn.us and	к ос	00		
	THE PLAN OF CC	DRRECTION FOR EACH				
	1. A description of to correct the defic	what has been, or will be, done siency.				
	2. The actual, or p	roposed, completion date.		1		
	responsible for cor	or title of the person rrection and monitoring to rence of the deficiency.				
	new 2012 Life Safe Home is a 1-story basement. The bu different times. The constructed in 196 Type II(111) constr constructed to the determined to be of 1981, another add Wing and was det 1991, an addition and was determine construction. In 20 1-story building with	surveyed as one building per ety Code. St. Mark's Lutheran building with a partial ilding was constructed at 4 e original building was 3 and was determined to be of 'uction. In 1967, addition was East Wing that was of Type II(111) construction. In lition was added to the East ermined to be Type V(111). In was added to the North Wing ed to be Type II (111) 013 another addition was a th no basement. The 2013 determined to be of Type V				
		s the construction type allowed gs, the facility was surveyed as lding.				

		AND HUMAN SERVICES			FORM OMB NO.	12/19/201 APPROVE 0938-039
ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE	SURVEY
		245369	B. WING		11/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ST MARI	KS LUTHERAN HOME	1		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
K 000	Continued From pa	ige 2	КO	00		
	fire alarm system w detection and spac monitored for autor notification. The fac	y sprinklered. The facility has a vith full corridor smoke es open to the corridors that is matic fire department cility has a capacity of 61 beds of 57 at the time of the survey.				
	NOT MET as evide	: 42 CFR, Subpart 483.70(a) is enced by: ion of Building Spaces -	К 3	72		12/22/16
	Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to terr Smoke dampers an penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1)	ding Spaces - Smoke Barrier all be constructed to a 1/2-hour ig per 8.5. Smoke barriers shall minate at an atrium wall. re not required in duct / ducted HVAC systems where ther system is installed for nts adjacent to the smoke				
	in REMARKS. This STANDARD in Subdivision of Buil Construction 2012 EXISTING Smoke barriers sha fire resistance ration shall be permitted to Smoke dampers and penetrations in fully an approved sprink	anical smoke control system is not met as evidenced by: Iding Spaces - Smoke Barrier all be constructed to a 1/2-hour to g per 8.5. Smoke barriers to terminate at an atrium wall. the not required in duct y ducted HVAC systems where ther system is installed for ints adjacent to the smoke		As of 11-18-2016 the pene the sprinkler piping above Silver Maple and memory have been sealed with fire As of 11-23-2016 all smok fire separation walls have for penetrations that are no	the doors in Care wings caulk. e barrier and been checked	

Event ID: 5S8S21

Facility ID: 00394

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES			FORM	2: 12/19/2016 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
		245369	B. WING	<u> </u>	11	/17/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	1		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
K 372	in REMARKS. On facility tour betw on Nov. 17, 2016, k interview revealed f 1.Penetrations arou found in the smoke Silver Maple wing a all smoke barrier at penetrations. This deficient pract the residents, staff compartment. This deficient pract	age 3 manical smoke control system ween 09:00 AM and 01:00 PM based on observation and that the findings include: and fire sprinkler piping were barrier walls above doors in and Memory care wing. Check and fire separations walls for tice could affect the safety of all and visitors within the smoke tice was confirmed by the be Director at the time of	K	372		

Facility ID: 00394

If continuation sheet Page 4 of 4



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted December 12, 2016

Mr. Murray Finger, Administrator St. Marks Lutheran Home 400 - 15th Avenue Southwest Austin, MN 55912

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5369026 and Complaint Number H5369059

Dear Mr. Finger:

The above facility was surveyed on November 15, 2016 through November 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5369059 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

St Marks Lutheran Home December 12, 2016 Page 2

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact **Gary Nederhoff, Unit Supervisor at (507) 206-2731.**

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u> St Marks Lutheran Home December 12, 2016 Page 3

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00394	B. WING		11/1	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	400 - 15TH AUSTIN, M		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 12/13/16

Electronically Signed

If continuation sheet 1 of 24

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00394	B. WING		11/	17/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
ST MARI	KS LUTHERAN HOM		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health.				
	this Department's s and the following c Please indicate in y correction that you	16, & 17, 2016, surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, the when they will be completed				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		00394	B. WING		11/	17/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME		TH AVENUE SC MN 55912	DUTHWEST		
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2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
		laint investigation was also ne of the licensing survey.				
		complaint H5369059 was mplaint was not substantiated				
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			12/27/10
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
		ter treatment significantly, for discontinue an existing form				

TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
		00394	B. WING		11/17	7/2016
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE		
				SOUTHWEST		
T MARI	KS LUTHERAN HOMI	-	MN 55912			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLE DATE
				DEFICIENCY)		
2 265	Continued From pa	ige 3	2 265			
	-	-				
	begin a new form of	adverse consequences, or to				
	D. a decision	to transfer or discharge the				
	resident from the n	ursing home; or				
	E. expected ar	nd unexpected resident deaths.				
	This MN Requirem	ent is not met as evidenced				
	by:					
		and document review, the		1. Corrective Action:		
		ure the physician was notified		A. Resident R 99, Staff educated		
		th status in regards to		change of condition policy and pr		
		ilure and weight gain following		steps taken to inform physician, f	amily and	
	death record was r	of 1 resident (R99) whose		B. Nurses and Nurse Managers e	ducated	
				on change of Acute Condition Ch		
	Findings include:			clinical protocol		
		to the nursing facility on		2. Corrective Action as it app	lies to	
		ocal hospital with diagnoses		other Residents:		
		s, dehydration, acute/chronic		A. will review Acute chan		
		nistory of a gastrointestinal sion Minimum Data Set (MDS)		Policy for all residents at POC me B. all Nursing staff will be educate		
		entified R99 had intact		monitoring for acute changes and		
	-	able to verbalize her needs.		needed to inform those necessa		
		ted 10/12/16, indicated		3. Date of Completion: Dec		
		ted to altered cardiovascular		27th, 2016		
		estive heart failure, peripheral		4. Reoccurrence will be prev		
		nd oxygen dependence.		A. Nursing staff educatio		
		led: Daily weights, monitor		Acute Changes Policy at POC me		
		signs weekly, notify MD significant abnormalities		B. Audits will be completed month results discussed at weekly risk	ily allu	
	(medical doctor) of significant abnormalities, monitor and document as needed changes in			Management meetings		
		scultation, edema and changes		5. Correction will be monitor	ed by:	
	in weight, monitor a	and document for signs and		A. DON or designee	-	
		ary artery disease including-		B. QAPI committee will review at		
		e, nausea, dependent edema,		quarterly basis and will provide fu	rther	
	changes in capillar	y refill, and color/warmth of		direction if needed		
	extremities.				1	

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If continuation sheet 4 of 24

D PLAN OF CORRECTION		A. BUILDING:		COIVI	PLETED
	00394	- B. WING		11/	17/2016
ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		11/2010
S LUTHERAN HOME	400 - 151	H AVENUE SC			
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 4	2 265			
R99's admission orders dated 10/12/16, included an order for torsemide 10 mg (diuretic) by mouth for weight gain greater than three pounds (lb) in 24 hours, or a 1 lb weight gain for greater than three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep O2 (oxygen) saturations greater than 90%.					
admission weight w and was document section of the electri On 10/31/16 the ne pounds a 12 pound been reported to th practitioner (NP)-A. on 11/1/16 with a lo not reported to the assessment comple taken on 11/2/16 ar and increase of 0.8 no respiratory asse	vas first recorded on 10/20/16, ed as 95.9 lbs in the weight ronic medical records (EMR). xt weight was recorded at 108 gain. This weight gain had no e physician or the nurse The third weight was taken ss of 3 pounds. Again this was physician nor a respiratory eted. The fourth weight was nd recorded as 105.8 pounds pounds and again there was ssment completed nor was	t			
indicated a messag practitioner (NP)-A inspiratory wheezes sounds, and three did not indicate the R99's weight gain (the next recorded v lb). A faxed respon- received by the fact appreciated the upo	the had been sent to the nurse at the clinic, regarding R99's s, lower lobe diminished breath blus pitting edema. The note NP-A had been informed of 10/20/16 weight 95.9 lb and weight dated 10/31/16 was 108 se from the NP-A had been lity on 10/31/16, indicating she date and wanted staff to				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From participation for weight gain great 24 hours, or a 1 lb w three days, or peda also ordered contin cannula 1 liter, to ke greater than 90%. Although R99 had k admission weight w and was document section of the electric On 10/31/16 the ne pounds a 12 pound been reported to the practitioner (NP)-A. on 11/1/16 with a lo not reported to the assessment complet taken on 11/2/16 ar and increase of 0.8 no respiratory asset the physician notifie A nurse's note docu indicated a message practitioner (NP)-A inspiratory wheezes sounds, and three p did not indicate the R99's weight gain (the next recorded w lb). A faxed respons received by the faci appreciated the up continue to keep h	S LUTHERAN HOME 400 - 15T AUSTIN, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 R99's admission orders dated 10/12/16, included an order for torsemide 10 mg (diuretic) by mouth for weight gain greater than three pounds (lb) in 24 hours, or a 1 lb weight gain for greater than three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep O2 (oxygen) saturations greater than 90%. Although R99 had been admitted on 10/12/16, an admission weight was first recorded on 10/20/16, and was documented as 95.9 lbs in the weight section of the electronic medical records (EMR). On 10/31/16 the next weight was recorded at 108 pounds a 12 pound gain. This weight gain had no been reported to the physician or the nurse practitioner (NP)-A. The third weight was taken on 11/1/16 with a loss of 3 pounds. Again this was not reported to the physician nor a respiratory assessment completed. The fourth weight was taken on 11/2/16 and recorded as 105.8 pounds and increase of 0.8 pounds and again there was no respiratory assessment completed nor was the physician notified of the weight gain. A nurse's note documented in the EMR 10/31/16, indicated a message had been sent to the nurse practitioner (NP)-A at the clinic, regarding R99's inspiratory wheezes, lower lobe diminished breatt sounds, and three plus pitting edema. The note did not indicate the NP-A had been informed of R99's weight gain (10/20/16 weight 95.9 lb and the next recorded weight dated 10/31/16 was 108 lb). A faxed response from the NP-A had been received by the facility on 10/31/16, indicating she appreciated the update and wanted staff to	SLUTHERAN HOME A00 - 15TH AVENUE SC AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 4 2 265 R99's admission orders dated 10/12/16, included an order for torsemide 10 mg (diuretic) by mouth for weight gain greater than three pounds (lb) in 24 hours, or a 1 lb weight gain for greater than three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep O2 (oxygen) saturations greater than 90%. Although R99 had been admitted on 10/12/16, an admission weight was first recorded on 10/20/16, and was documented as 95.9 lbs in the weight section of the electronic medical records (EMR). On 10/31/16 the next weight was recorded at 108 pounds a 12 pound gain. 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S LUTHERAN HOME 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912 Image: SumMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Deficiency Misting Precedence TAG Image: Deficiency Misting Precedence TAG PREMIXER PREMIXER Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 2 265 2 Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 2 265 Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 2 265 Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 2 265 Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 2 265 Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continued From page 4 10 misting and precedence Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Image: Deficiency Misting Precedence CROSS-REFERENCED TO THIP DEFICIENCY Continue 1 life, to keep O2 (oxygen) saturations greater than 90%. Image: Deficiency Misting Precedence Deficiency Misting Precedence Deficiency Misting Precedence Deficiency Misting Precedence Precedence The Precedence Precedence The Precedence Deficiency Misting Precedence Deficiency Misting Precedence Deficiency Misting Precedence Deficiency Misting Pre	S LUTHERAN HOME 400 - 15TH AVENUE SOUTHWEST AUSTIN, MIX 55912 Image: Summary Statement of DEFICIENCES RECHORENCEMENT WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION. In PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 4 2 265 R99's admission orders dated 10/12/16, included an order for torsemide 10 mg (diuretic) by mouth for weight gain greater than three pounds (lb) in 24 hours, or a 1 lb weight gain for greater than three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep O2 (oxygen) saturations greater than 90%. 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2 265	meeting note ident have 3+ edema in weekend, had a 10 utilized the torsemi indicated the occup hold the lympheder overload was back indication the phys notified of the weig The electronic med identified R99 had consecutive days of 11/2/16 due to weig indication the facilit pulmonary status a had they updated t pound weight gain torsemide.	ified R99 had been noted to her lower extremities over the 0 lb weight gain, and had ide. The IDT note also pational therapist was going to ma treatment until her fluid in line. There was no ician or the NP-A had been ht gain. dication administration record received torsemide three on 10/31/16, 11/1/16, and ght gain. There was no ty had assessed R99's as part of the assessment, nor he physician about R99's 10 and subsequent use of	2 265			
	experienced an inc notes documented R99 was yelling ou staff, and was very indicated as long a room, she was call leave her room she indicated the reside up phlegm" and inc staff had seen an " behaviors." Again physician or the NF	ew indicated R99 had crease in behaviors. Nursing 11/2/16 at 1:05 p.m. indicated it, attempting to strike out at demanding. The note is staff remained in R99's m but when staff started to e would yell out help. The note ent stated she was "coughing dicated this was the first time increase in anxiety and there was no indication the P-A had been updated as to the behaviors indication oxygen				
	indicated R99 had and was upset. Th	R dated 11/2/16 at 1:57 p.m., been speaking to the chaplain he note indicated the resident uld not breathe and "they don't				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	4	DRESS, CITY, S			17/2010
		400 - 15T	H AVENUE SC			
	KS LUTHERAN HOM	E AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 265	Continued From pa	age 6	2 265			
	believe me." Accor the Chaplain, and t the resident and tri indicated: "Resider and stated that he today" and indicate had been checked increased the oxyg Again no timely no NP-A in regards to Another EMR entry indicated: "[family no verbal ok over the ER (emergency roo 7:03 p.m. on 11/2/1 EMR that indicated from the local hosp Rochester due req due to pulmonary e was reviewed furth documentation fou contacted the phys gain, anxiety, breat status. Instead, the family to obtain per emergency room. An entry in the EM FM-A had notified to on 11/6/16. During an interview (RN-M) manager of stated she had beet trouble breathing, I extremity edema.	rding to the EMR note, an aide, the social worker talked with red to comfort her. The note in twas asking for her doctor was going to come again ad the resident's oxygen levels and the nursing assistant had gen at the nurse's request. tification of the physician or having difficulty breathing. y from 2:02 p.m. 11/2/16, member's name (FM-A)] gave phone to transfer resident to om) for eval and treatment." At 16, there was an entry in the d R99 had been transferred bital to St. Mary's Hospital in uiring a higher level of care edema. The resident's record her, and there was no nd to indicate the facility had sician regarding R99's weight thing difficulty and pulmonary e facility staff had contacted the rmission to send R99 to the R dated 11/7/16, indicated the nursing home that R99 died with the registered nurse on 11/16/16 at 2:43 p.m., RN-M en aware R99 was having had anxiety and had lower RN-M stated she had assessed equently provided direction to				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
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2 265	emergency room. W notified the physicia she had not contact because it could hat them to call back." include any docume condition prior to he On 11/16/16 at 2:3 worker (LSW) was recalled having bee unknown nursing at The LSW stated RS weekend before ho documentation of a The LSW stated RS agitated which she become short of bro When interviewed of director of nursing (been weighed daily admission weight w within the first 24 ho DON confirmed the identified by RN-M. A request was mad change and was no An undated policy, The policy did not a process for obtainin SUGGESTED MET The director of nursi procedures related medical conditions,	When asked whether she had an prior to transfer, RN-M said ted the resident's physician we taken a "day and a half for Review of the EMR failed to ented assessment of R99's er being sent to the hospital. 1 p.m., the licensed social interviewed. The LSW en in R99's room with an ssistant (NA) and the chaplain. 29 had been hallucinating the wever, there was no ny hallucinations in the EMR. 29 had been very scared and thought had caused R99 to eath. 20 n11/16/16 at 3:32 p.m., the (DON) stated R99 should have and the expectation for an vas that it would be obtained burs from admission. The e lack of weights had been e for a policy related to status of provided. for "weights" was reviewed. address the nursing facility's ng weights. THOD OF CORRECTION: sing could develop policies and to how to assess resident educate staff regarding these esident records for compliance						

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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ST MARI	KS LUTHERAN HOME		HAVENUE S MN 55912	OUTHWEST		
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)		DATE
2 265	Continued From pa	ge 8	2 265			
	TIME PERIOD FOF days.	R CORRECTION: Seven (7)				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			12/27/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to ade interventions to trea resident (R99) who The facility's failure assessment and int R99 who suffered a requiring subseque Findings include: R99 was admitted t 10/12/16, from a lo including: weakness kidney injury, and h bleed. R99's admis	ent is not met as evidenced and document review, the quately assess and implement at fluid retention for 1 of 1 se death record was reviewed. to provide adequate tervention resulted in harm for unxiety and difficulty breathing nt hospitalization. o the nursing facility on to al hospital with diagnoses s, dehydration, acute/chronic istory of a gastrointestinal sion Minimum Data Set (MDS) ntified R99 had intact		 Corrective Action: Resident R 99, Staff educated change of Acute Condition Policy a proper steps taken to inform physifamily and resident Nursing staff and Nurse Manage educated on change of Acute Cond Changes- clinical protocol 	and cian, ers dition es to ges eting d on steps Y	

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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 9	2 830			
	R99's care plan da problem areas rela status due to conge vascular disease a Interventions inclue pedal edema, vital doctor of significan document as need auscultation, edem and document for s coronary artery dise pressure, nausea,	cognition and was able to verbalize her needs. R99's care plan dated 10/12/16, indicated problem areas related to altered cardiovascular status due to congestive heart failure, peripheral vascular disease and oxygen dependence. Interventions included: Daily weights, monitor pedal edema, vital signs weekly, notify medical doctor of significant abnormalities, monitor and document as needed changes in lung sounds on auscultation, edema, changes in weight, monitor and document for signs and symptoms of coronary artery disease including- chest pain, pressure, nausea, dependent edema, changes in capillary refill, and change in color/warmth of		 27th, 2016 4. Reoccurrence will A. Nursing staff Acute Changes Policy at B. Audits will be complete results discussed at week Management meetings 5. Correction will be A. DON or desig B. QAPI committee will re quarterly basis and will pr direction if needed 	education on POC meeting ed monthly and kly risk monitored by: nee eview audits on a	
	an order for torsem for weight gain grea 24 hours, or a 1 lb three days, or peda also ordered contin	rders dated 10/12/16, included hide 10 mg (diuretic) by mouth ater than three pounds (lb) in weight gain for greater than al edema. The physician had huous oxygen via nasal eep oxygen (O2) saturations rcent (%).				
	10/12/16, the first v 10/20/16 (eight day documented as 95.	been admitted to the facility on veight completed was on vs after admission), and was .9 lbs found in the weight ronic medical records (EMR).				
	included on R99's of included weights sh	on orders from the hospital and comprehensive care plan hould be monitored daily, there ditional weights documented				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	for rehabilitation, and therapy services. T with activities of da deconditioning whice therapy. The progree documented concer- breathing, pulmonar- edema. A nurse's note docer 10/31/16, indicated the nurse practition regarding R99's have lower lobe diminish plus pitting edema. NP-A had been infor 12 pounds from 10 10/31/16 was 108 I NP-A had been reconstruction 10/31/16, indicating	tified R99 had been admitted nd continued to receive The note identified limitation ily living, ambulation and ch required rest periods for ess noted did not include any erns related to the resident's ary status, weight gain or umented in the EMR dated I a message had been sent to her (NP)-A at the local clinic, aving inspiratory wheezes, hed breath sounds, and three The note did not indicate the pormed of R99's weight gain of 1/20/16 weight 95.9 lb and on lb. A faxed response from the ceived by the facility on g she appreciated the update to continue to keep her updated	8			
	meeting note identi have 3+ edema in weekend, had a 10 utilized the torsemi also indicated the o going to hold the ly fluid overload was					
	identified R99 had consecutive days of 11/2/16 due to weig no indication the fa pulmonary status (I health assessment	dication administration record received torsemide for three on 10/31/16, 11/1/16, and ght gain. However, there was icility had fully assessed R99's breathing) as part of the overal especially with the over 10 in one day, nor had they				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00394	B. WING		11/17/2016	
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		400 - 151	H AVENUE SO			
	KS LUTHERAN HOMI	E AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 830	Continued From pa	age 11	2 830			
		ian/NP-A about R99's 10 and subsequent use of				
	experienced an inc Nursing notes docu indicated R99 was out at staff, and wa indicated as long a room, she was calr leave her room she note indicated the r "coughing up phleg	ew indicated R99 had grease in anxiety behaviors. umented 11/2/16 at 1:05 p.m. yelling out, attempting to strike is very demanding. The note s staff remained in R99's in but when staff started to e would yell out for help. The resident stated she was ym" and indicated this was the seen an "increase in anxiety				
	indicated R99 had and was upset. The the resident had sta "they don't believe note, an aide, the C worker talked with comfort her. The ne asking for her doct going to come again resident's oxygen le	R dated 11/2/16 at 1:57 p.m., been speaking to the chaplain e note indicated during the visit ated she could not breathe and me." According to the EMR Chaplain, and the facility social the resident and tried to ote indicated: "Resident was or and stated that he was in today" and indicated the evels had been checked and nt had increased the oxygen request.				
	indicated: "[family r ok over the phone [emergency room] 11/2/16 at 7:03 p.m EMR that indicated from the local hosp Rochester due to r	v dated 11/2/16 at 2:02 p.m. nember (FM)-A] gave a verbal to transfer resident to ER for eval and treatment." On n. there was an entry in the I R99 had been transferred bital to St. Mary's Hospital in equiring a higher level of care edema. The resident's record				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
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ST MAR	KS LUTHERAN HOME	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	nge 12	2 830			
	was reviewed furth documentation four contacted the phys gain, increased any decline in pulmona was an admission of facility staff had con permission to send An entry in the EMI	er, and there was no nd to indicate the facility had ician regarding R99's weight kiety, breathing difficulty and ry status. Even though there order to do so. Instead, the ntacted the family to obtain R99 to the emergency room. R dated 11/7/16, indicated he nursing home that R99 died				
(RN)-M a RN-M stathaving tro lower extrassessed direction to call the fathe emergy had notifies said she high physician a half for the failed to in R99's contractions	(RN)-M a manager RN-M stated she h having trouble brea lower extremity ede assessed R99 and direction to the lice call the family for p the emergency roo had notified the phy said she had not co physician because a half for them to co failed to include any	with the registered nurse on 11/16/16 at 2:43 p.m., ad been aware R99 was tthing, had anxiety and had ema. RN-M stated she had had subsequently provided ensed practical nurse (LPN) to ermission to transfer R99 to m. When asked whether she ysician prior to transfer, RN-M ontacted the resident's it could have taken a "day and all back." Review of the EMR y documented assessment of or to her being sent to the				
	11/16/16, RN-M col and verified a weigh until the 8th day aft was supposed to he said when she had weighed per protoc educated all day sh weights are done o	w with RN-M at 2:43 p.m. on nfirmed R99's admission date, ht had not been documented er admission even though R99 ave been weighed daily. RN-M realized R99 had not been sol, she said she immediately nift nursing staff because the n the day shift. RN-M stated g this process. The education	1			

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST MAR	KS LUTHERAN HOM		H AVENUE SO MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830		-	2 830			
		vith staff signatures to confirm eived training per the RNM.				
		0 p.m. a phone message was return a call for an interview				
w re U T d T a	worker (LSW) was recalled having bee unknown nursing a The LSW stated R weekend before ho documentation of a The LSW stated R	1 p.m., the licensed social interviewed. The LSW en in R99's room with an assistant (NA) and the chaplain 99 had been hallucinating the owever, there was no any hallucinations in the EMR. 99 had been very scared and thought had caused R99 to reath.				
	director of nursing been weighed daily admission weight v within the first 24 h DON confirmed the identified by RN-M	on 11/16/16 at 3:32 p.m., the (DON) stated R99 should have and the expectation for an vas that it would be obtained ours from admission. The e lack of weights had been and as a result staff education and monitoring of weights had				
	change and was no An undated policy,	for "weights" was reviewed. address the nursing facility's				
	The director of nur procedures related medical conditions	THOD OF CORRECTION: sing could develop policies and to how to assess resident , educate staff regarding these resident records for compliance and procedures.				

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If continuation sheet 14 of 24

STATEME	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ST MAR	KS LUTHERAN HOME		HAVENUE S MN 55912	GOUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 830	Continued From pa	ge 14	2 830		
	TIME PERIOD FOR days.	R CORRECTION: Seven (7)			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375		12/27/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on interview failed to maintain a that tracked and an trends, failed to ide infections (UTI's), f and document reso residents (R11, R74 who experienced U Findings included: Tracking and Analy The facility' s Month and Monthly Infection 1/16 through 10/16 identified the follow -1/16: 6 infections (-2/16: 4 UTI's; -3/16: 8 infections (-4/16: 3 infections (sis of Infections hly Infection Control Reports on Logs were obtained from . The monthly records ing: 3-UTI's); 6 were UTI's); 1 was UTI's); 6 were UTI's); 1 did not nfection; r logs available;		 A. Corrective Action: C. St. Mark s will establish an infection control program which will: "Investigate, control and prevent infections in the facility "Decides which isolation should be applied to an individual resident "Maintains a record of incidents and corrective actions related to infections D. Preventing the spread of infections: "Determining the proper need for isolation to prevent the spread of infections Prohibit employees with communicable disease or infected skin lesions from direct contact with resident and their food if direct contact will spreat the disease "St. Marks will require that employees wash their hands after direct contact with residents "Laundry must handle, store and process and transport linens so as to prevent the spread of infection. 	on s d

Minnesota Department of Health STATE FORM

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STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00394	B. WING		11/17/2016	
	PROVIDER OR SUPPLIER KS LUTHERAN HOME	400 - 15TH	AVENUE S	STATE, ZIP CODE SOUTHWEST		
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21375	-8/16: 7 infections (of the 4); -9/16: 4 infections (-10/16: 11 infection The records lacked infections for the m identification wheth and/or community a consistent document symptoms, culture The facility provided nursing assistant m education of UTI's a and video and nurs 8/24/16, included in hand hygiene and g meeting 8/24/16, in hand hygiene and g meeting 8/24/16, in hand hygiene and g In addition, the reco analysis of infection identification of outli implementing and o related problems. UTI Monitoring (Cu R11's progress note administration reco following: -7/28/16, complains complains back pai urination and foul s emergency departm diagnosis of UTI. G Levaquin (antibiotic (milligrams) daily for call to change antib	4 were UTI; 1 was urosepsis 3 were UTI's); s (7 were UTI's). I the following: tracking of onth of June 2016, er the infections were in house acquired, date resolved and ntation of signs and results and date onset. d the following information: heeting dated 5/19/16, included and catheter care handouts e's meeting agenda on hfection control issue, UTI's, glove use. Nursing assistant cluded infection control issues glove use. brds failed to include an hs, which included breaks of infection as well as documenting actions to resolve Iture Results and Resolution)	21375	 Corrective Action as it other Residents: A. St. Mark □s will establish a control program for all resider prevents the spread of infecti B. Nursing staff will b on infection control program a meeting Date of Completion: 127th, 2016 	n infection nts that ons e educated at POC December prevented by: e educated at POC ing of se as well as nonthly and hitored by: w audits on a	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	1	
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21375	dated 7/16 and 8/1 received Levaquin 8/1/16 and Cefdinin days, starting 8/2/1 include culture rest resolution of the U -10/24/16, sent to I reactions. Returne UTI. 10/25/16, Cef times seven days. Temp 99.3. 10/27/ UTI. Temp 96.3. N discomfort. R11's N R11 received Cefd seven days. R11's results and docum UTI. R74's progress not administration reco following: -9/19/16 patient ha	6 identified the resident 500 mg daily on 7/31/16, r 300 mg twice daily for 10 6. R11 ' s record failed to ults and documentation of TI. ED, having hypoglycemic d with orders for antibiotic for dinir 300 mg two times a day 10/26/16, on antibiotic for UTI. 16, continues on antibiotic for o complaints of any pain or MAR dated 10/16, identified inir 300 mg two times daily for record failed to include culture entation of resolution of the tes and medication ord (MAR) identified the s not been herself, very slow in	21375			
	ED. Returned from UTI, Cipro 250 mg R74's MAR dated s received Cipro 250 days. Documentati culture results and resolution. R43's progress not	bond or eat. Order to send to a the hospital, new orders for twice daily for seven days. 9/16 identified the resident 0 mg two times a day for seven on in R74's record lacked documentation of UTI tes and medication ord (MAR) identified the				
negata D	-7/6/16, confused a needed to use the orders for acquire with results. Urine evaluation. 7/7/16	and pulling at catheter stated bathroom. Hospice wrote urine culture and page Hospice obtained and sent to lab for urine results, Cipro 250 mg ays. 7/9/16 follow up urine				

ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED			
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PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE					
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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
Continued From pa when antibiotic is d once asking to void complaints of pain. daily for 10 days, c 8/2/16 fax stating u medications excep expensive. Not able kidney function. Wit treatment. Physicia medication tomorro for 7 doses. R43's received Cipro 250 The facility failed to for the UTI noted 8 include culture resu treatment and docu UTI's for 7/6/16 and R36's progress not following: -9/2/16-combative behaviors with son be sent. Resident e sample. Resident e yelling out. There is orders for an antibi 9/3/16 Cephalexin for UTI. R36's MAF received Cephalex days. Documentat include culture resu R22's progress not following: -6/27/16 resident s leaning to the left w	age 17 lone on 7/18/16; 7/10/16-up d, reminded had a catheter. No 7/17/16 R43 on Cipro 2 times ompleted antibiotic course. Irine resistant to all oral t linezolid which is very e to take nitrofurantoin due to fe called regarding antibiotic an faxed orders start ow and will be every other day MAR dated 7/16 identified R43 mg 2 times daily for 10 days. o provide any other information /2/16. R43's record failed to ults for the 8/2/16 UTI umentation of resolution of the d 8/2/16. es and MAR identified the with cares and having . Hospice contacted, nurse will son request to obtain a urine extremely anxious, restless and s a potential for a UTI and has otic to start in the morning. 250 mg 4 times/day for 7 days R dated 9/16 identified R36 in 250 mg four times daily for 7 ion in R36's record failed to ults and resolution of the UTI. es and MAR identified the	21375	DEFICIENC	Υ)				
	PROVIDER OR SUPPLIER (S LUTHERAN HOMI SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From pa when antibiotic is d once asking to void complaints of pain. daily for 10 days, c 8/2/16 fax stating u medications excep expensive. Not able kidney function. Wi treatment. Physicia medication tomorrow for 7 doses. R43's received Cipro 2500 The facility failed to for the UTI noted 8 include culture result treatment and docu UTI's for 7/6/16 and R36's progress not following: -9/2/16-combative behaviors with son be sent. Resident est sample. Resident est sample. Resident est and complexity for UTI. R36's MAF received Cephalexin for UTI. R36's MAF received	OF CORRECTION IDENTIFICATION NUMBER: 00394 00394 PROVIDER OR SUPPLIER STREET AI SLUTHERAN HOME 400 - 151 AUSTIN, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 When antibiotic is done on 7/18/16; 7/10/16-up once asking to void, reminded had a catheter. No complaints of pain. 7/17/16 R43 on Cipro 2 times daily for 10 days, completed antibiotic course. 8/2/16 fax stating urine resistant to all oral medications except linezolid which is very expensive. Not able to take nitrofurantoin due to kidney function. Wife called regarding antibiotic treatment. Physician faxed orders start medication tomorrow and will be every other day for 7 doses. R43's MAR dated 7/16 identified R43 received Cipro 250 mg 2 times daily for 10 days. The facility failed to provide any other information for the UTI noted 8/2/16. R43's record failed to include culture results for the 8/2/16 UTI treatment and documentation of resolution of the UTI's for 7/6/16 and 8/2/16. R36's progress notes and MAR identified the following: -9/2/16-combative with cares and having behaviors with son. Hospice contacted, nurse will be sent. Resident son request to obtain a urine sample. Resident extremely anxious, restless and yelling out. There is a potential for a UTI and has orders for an antibiotic to start in the morning. 9/3/16 Cephalexin 250 mg four times daily for 7 days. Documentation in R36's record failed to include culture results and resolution of the UTI. R22's progress notes and MAR identified the following: -6/27/16 resident seen sitting in wheelchair leaning to the	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00394 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S' SLUTHERAN HOME 400 - 15TH AVENUE SC SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 17 21375 when antibiotic is done on 7/18/16; 7/10/16-up ID OCCOMPLATION OF 10 days, completed antibiotic course. 8/2/16 fax stating urine resistant to all oral medications except linezolid which is very expensive. Not able to take nitrofurantion due to kidney function. Wife called regarding antibiotic treatment. Physician faxed orders start medication tomorrow and will be every other day for 7 doses. R43's MAR dated 7/16 identified R43 received Cipro 250 mg 2 times daily for 10 days. The facility failed to provide any other information for the UTI noted 8/2/16. R36's progress notes and MAR identified the following: -9/2/16-combative with cares and having behaviors with son. Hospice contacted, nurse will be sent. Resident extremely anxious, restless and yelling out. There is a potential for a UTI and has orders for an antibiotic to start in the morning. 9/3/16 Cephalexin 250 mg four times daily for 7 days for UTI. R36's MAR dated 9/16 identified R36 received Cephalexin 250 mg four times daily for 7	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00394 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SSLUTHERAN HOME 400 - 1STH AVENUE SOUTHWEST AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) Continued From page 17 21375 CROSS-REFERENCED TO DEFICIENCY when antibiotic is done on 7/18/16; 7/10/16-up once asking to void, reminded had a catheter. No complaints of pain. 7/17/16 R43 on Cipro 2 times daily for 10 days, completed antibiotic course. 8/2/16 fax stating urine resistant to all oral medications except linezolid which is very expensive. Not able to take nitrofurantoin due to kidney function. Wife called regarding antibiotic treatment. Physician faxed orders start medication tomorrow and will be every other day for 7 doses. R43's MAR dated 7/16 identified R43 received Cipro 250 mg 2 times daily for 10 days. The facility failed to provide any other information for the UTI noted 8/2/16. R43's record failed to include culture results for the 8/2/16 UTI treatment and documentation of resolution of the UTI's for 7/6/16 and 8/2/16. R36's progress notes and MAR identified the following: -9/2/16-combative with cares and having behaviors with son. Hospice contacted, nurse will be sent. Resident son request to obtain a urine sample. Resident son request to obtain a urine sample. Resident son request to obtain a urine sample. Resident son song four times daily for 7 days. Documentation in R36's record failed to include culture results and resolution of the UTI. R22's progress notes and MAR identified the following: -0/27/16 resident s	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING:			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	resident on Levaque IV dose and returne 750 mg daily for 5 of Levaquin and start for 7 days. Review R22 received Leva R22's record failed documentation of r On 11/17/16, at 12: (RN)-C stated she infection control (IC infection control mod absent for the mon explained that durin nursing (DON) was monitoring. RN-C v did not include all r analysis of infection RN-C verified resol documented. The facility policy Ir Prevention Program	age 18 in and they administered R22 ed with orders for Levaquin days. 7/1/16 discontinue Macrobid 100 mg twice daily of the June MAR identified quin and Macrobid as ordered. to include culture results and esolution of the UTI. 306 p.m., registered nurse was responsible for the C) program, starting with pontoring April 2016 and was ths of July and August. She ng her absence the director of a responsible for the IC rerified tracking of infections equired information and ns had not been documented. lution of UTI's was not being infection Control and n, dated 5/11, indicated the plements, maintains an	21375			
	Infection Prevention to prevent, recognize possible, the onset the facility. Procedu designated to serve infection prevention nurse is considered Preventionist (IP). S with infection control	n and Control Program in order ze, and control, to the extent and spread of infection within ure: 1) A registered nurse is a scoordinator of the n and control program. The d the facility's Infection Staff are assigned to assist ol program, as needed. Duties				
anacata D	Overseeing staff/vo control policies and annually and as ne tracking of infectior	de but are not limited to: b) blunteer training on infection I procedures upon hire, eded; d) Overseeing the hs, monthly infection reports, lew by the Quality Assurance				

Minneso	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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21375	Continued From pa	ige 19	21375			
	to develop corrective any errors, problem the infection contro Monitoring antibioti The facility policy In dated 2/16, indicate Policy: Signs and s continually monitor Purpose: To identify treatment and infect put into place; to co disease. Procedure: (1.) Date for current signs/sy	nfection Control Surveillance, ed: symptoms of infection are				
	record occurs at lea absence of sympto symptoms subside dose of antibiotics. log frequently and r criteria) infections of Monthly: the IP con report. The report is	ast daily in presence or ms until 48 hours after the or until 48 hours after the last The IP monitors the infection records confirmed (meet on a monthly infection log. (2.) npletes the monthly infection s forwarded to the director of nly report includes a				
	director of nursing need to follow the f	THOD OF CORRECTION: The could in-service staff on the acility policy and procedure for ion program to prevent the s.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			12/27/16
Minnesota D STATE FORI	epartment of Health M		6899	5S8S11	If continuati	on sheet 20 of 24

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		AUSTIN,	MN 55912			
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21426	Continued From pa	age 20	21426			
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.				
	by: Based on interview facility failed to ens had a tuberculosis two step tuberculos failed to ensure 3 of two step TST's incl administration and of 5 residents (R92 read and failed to end been educated for plan. This had the	ent is not met as evidenced and document review, the sure 2 of 5 employees (E2, E3) (TB) symptom screening and sis skin test (TST) completed; of 5 employees (E1, E4, E5) luded the times of results read; failed to ensure 1 ensure all the employees had the facility TB infection control potential to affect all 56 iility, staff and visitors.		 Corrective Action: A. St. Mark S Living will review r recent TB prevention and control and Procedure issued by the CD0 B. St. Mark S Living TB policy wi all paid and unpaid employees, contractors, students, residents a volunteers C. TB policy is in place and writte compliance is maintained by St. M Living Corrective Action as it app other Residents: 	Policy C Il cover nd n ∕lark⊡s	

STATE FORM

STATEME	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00394	B. WING		11/17/2016	
ST MAR		400 - 15TI AUSTIN, I TEMENT OF DEFICIENCIES	H AVENUE \$ MN 55912	STATE, ZIP CODE SOUTHWEST PROVIDER'S PLAN OF COP		(X5)
PREFIX TAG 21426	REGULATORY OR L	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG 21426	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLE DATE
21420	Employee TB symp administration: E2 had a hire date a TB screen dated dated 5/12/15 and s The facility failed to screening and first hire as required. E3 had a hire date provided a TB scree TST dated 3/3/15 a The facility failed to screening and first hire as required. When interviewed or registered nurse (R TST Times of Admi E1 had a first step The TST was read include the time read on 4/20/16, at 4:00 failed to include the E4 had a first step and read on 3/2/16 was given on 3/14/ failed to include the time read. E5 had a first step 1/7/16, but failed to administration and TST was given on 3/	of 2/5/16. The facility provided 5/12/15 and first step TST second step dated 5/26/15. complete a TB symptom and second step TST upon of 2/17/16. The facility en dated 3/3/15 and first step nd second step dated 3/1615. complete a TB symptom and second step TST upon on 11/17/16, at 12:06 p.m., N)-C verified the above. nistration and Read Results: TST on 4/7/16, at 2:29 p.m. on 4/10/16, but failed to ad. The second TST was given p.m. and read on 4/22/16, but e time read. TST on 2/29/16, at 12:45 p.m., , at 1:00 p.m. The second TST 16 and read on 3/17/16, but e time of administration and the TST on 1/5/16 and read on		 A. Nursing staff will be education most recent distribution by the Prevention and Control Policy meeting December 20th, 20 B. St. Mark □s Living will have most Recent TB policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. St. Mark □s Living will keet documentation of all TB □s policy C. Date of Completion: December 2016 S. Correction will be educated and results discussed. D. Correction will be modeled. S. Correction will be modeled. B. QAPI committee will revise quarterly basis and will provide direction if needed. 	ne CDC for TB cy at POC 16 ve in place the ep written her policy cember 27th, e prevented by: Il be ssed at QAPI ated on most prevention C meeting onitored by: e ew audits on a	

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00394		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		11 / [.]	11/17/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
	KS LUTHERAN HOMI	- 400 - 15T	H AVENUE SO	OUTHWEST			
	KS LUTHERAN HOM	AUSTIN,	MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE		
21426	Continued From page 22		21426				
	The facility failed to include the time of administration and the time read for TST's to ensure the readings of the first and second step TST's were read within the 48 to 72 hours as required.						
	When interviewed on 11/17/16, at 12:06 p.m., RN-C verified the above.						
	baseline TB screer record indicated a s	on 8/4/16. R92's had a a and a first step TST. R92's second step TST was given on the record failed to include the nd TST.					
	On 11/17/16, at 12:06 p.m., RN-C verified the above.						
	facility had not com employees regardin control plan. RN-C	06 p.m., RN-C confirmed the pleted TB education with ng the facility TB infection confirmed the TB education mputer system failed to include tion control plan.					
	and Control, dated with state and fede must ensure that e and volunteers prio freedom from activ volunteers will have necessary for TB. 3 be in place for emp	uberculosis (TB) Prevention 2/16, indicated in accordance ral law health care facilities mployees, prior to employment or to volunteering show e TB. Employees and e initial and periodic testing if 3. An education program will ployees/volunteers. This will					
	suspected or active	surveillance and policies in the event of a e case of TB at which time ort are provided for the					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00394		B. WING		11/	11/17/2016	
AME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
T MAR	KS LUTHERAN HOM		H AVENUE SC MN 55912	DUTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE COMPLE HE APPROPRIATE DATE		
21426	employs/volunteer. of hire is required f Minnesota. Baselin components (1) as of active TB diseas presence of infection TST or single TB b receive baseline TB admission or within Baseline screening (3) testing for the p administering wither blood test. SUGGESTED MET director of nursing policies and proceon The director of nursing employees regarding facility infection cor nursing could monit and TST for employees	age 23 Baseline screening at the time or all health care workers in e TB screening consists of two sessing for current symptoms the and (2) testing for the on by administering a two-step lood test. All residents will B screening within 72 hours of a 3 months prior to admission. I consists of three components resence of infection by er a two-step TST or a single THOD OF CORRECTION: The could review tuberculosis dures to ensure compliance. sing could educate all ng TB education and the ntrol plan. The director of tor compliance for screening yees and residents. R CORRECTION: Twenty-one	21426	DEFICIENC	ΥΥ) 		