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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5S8S

Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245369**

2. STATE VENDOR OR MEDICAID NO. (L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LUTHERAN HOME**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **7** (L8)

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

8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/16/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)

0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 04/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 4/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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,

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,

Kamala 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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245369		2/16/2017

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 02/16/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 02/21/2017	SIGNATURE OF SURVEYOR 15425	DATE 2/16/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 :

- 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,

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00394 Y1	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 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 02/16/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 2/21/2017	SIGNATURE OF SURVEYOR 15425	DATE 2/16/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5S8S
Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245369**
2. STATE VENDOR OR MEDICAID NO. (L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LUTHERAN HOME**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **01/19/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **61** (L18)
13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

An equal opportunity employer.

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

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
Email: gary.nederhoff@state.mn.us
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:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 1/19/17. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	{F 441}		2/8/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize their infection control program/policy in regards to completing the resolution for Urinary Tract Infections (UTIs) for 2 of 4 residents (R40 and R2) reviewed who experienced UTIs. Findings included: The facility's Monthly Infection Control Reports and Monthly Infection Logs were requested and provided on 1/19/17 from 12/2016 and 1/2017 logs. The following was included on these logs: 12/2016 there were 3 infections with two being UTIs 1/2017 there were 6 infections with three being	{F 441}	1. Corrective Action: A. R40 an R2, nursing staff educated on Infection Control Program/Policy in regards to completing the resolution of UTI s. B. St. Mark s Nursing staff and Nurse Managers educated on Infection Control Program/Policy for antibiotic use and charting for resolution of signs and symptoms. 2. Corrective Action as it applies to other Residents: A. Will review Infection Control Program related to antibiotic use and the need for follow up charting once resident has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 2 UTIs and one kidney infection/UTI. The logs lacked the date and resolution the UTIs had resolved. R40's progress notes and medication administration record (MAR) identified on 12/29/16 that R40 had not felt well, had emesis. On 1/6/17 note R40's catheter needed to be changed due to sediment in tubing, additional 300 millimeters of dark urine output noted thick sediment. Note dated 1/7/17 included R40 had no urine output for 16 hours after a second catheter change, had been sent to emergency room (ER). Returned with diagnosis of pyelonephritis (kidney infection) new order for Bactrim DS 800 mg/160 mg twice daily for five days. Note dated 1/8/17 R40 had temperature of 101.2 degrees Fahrenheit, urine output 75 milliliters by 2 p.m., at 3:30 p.m. blood coming from tip of penis, sent to ER at 4:45 p.m. and received an order to increase fluids. Return from ER with diagnosis of dehydration and UTI continue with antibiotic. Completion of antibiotic was 1/12/17. R40's record failed to have documentation of resolution of UTI after the completion of the antibiotic. R2's progress notes and medication administration record (MAR) identified on 12/29/16, R2 had been sent to Urology for a urinary catheter change, order to start three days of Ciprofloxacin 500 mg twice daily for three days. Note dated 12/30/16 R2 had been sent to ER for left sided weakness and difficult to arouse. Note dated 12/31/16, R2 returned with diagnosis of stroke and UTI. Given dose of Cednifir (antibiotic) 600 milligrams in the ER and to continue dose of 300 mg twice daily for seven days. Note dated 1/4/17 included the lab called facility and R2 had	{F 441}	completed the course of antibiotics for all residents at POC meeting, January 31st, 2017 B. All Nursing staff will be educated on charting following the use of antibiotic use and signs and symptoms resolved. C. In PCC an area has been added for reminder for nurses to chart on follow up antibiotic use for residents. 3. Date of Completion: February 8th, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting, January, 31st, 2017 B. Audits will be completed monthly and results discussed at weekly Risk Management meetings 5. Correction will be monitored by: A. Staff Developer/Infection Control RN and DON B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 3	{F 441}		

culture results of E. Coli. The MAR reads continued with both antibiotics of ciprofloxacin and cednifir. Completion of Antibiotic regime was on 1/7/17. However, R2's record failed to have resolution of the UTI after completion of the two antibiotic.

On 1/19/17 at 2:36 p.m., registered nurse (RN)-B stated she was responsible for the infection control (IC) program. RN-B stated that she has been working on the program and trying to get it "straightened out" since last survey visit (exit on 11/17/16). RN-B stated they had included the need to document the resolution of signs and symptoms after the completion of the antibiotic for UTIs. RN-B verified resolution of UTIs had not been documented for either R40 or R2.

On 1/19/17 at 4:51 p.m. Director of Nursing said she expected staff to follow the infection policy, which includes monitoring of resident to determine if antibiotic was affective and on completion of antibiotic use to document resolution of UTIs. And if no resolution to notify the doctor.

The facility policy Infection Control Surveillance, dated 2/16, indicated:
Procedure: Documentation in the clinical record occurs at least daily in the presence or absence of symptoms until 48 hours after the symptoms or until 48 hours after the last dose of antibiotics.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245369		1/19/2017

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 12/27/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 12/27/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 01/19/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 SURVEY COMPLETED ON
11/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245369	A. Building 01 - MAIN BUILDING 01 B. Wing	12/19/2016

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/22/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/20/2017	SIGNATURE OF SURVEYOR 37008	DATE 12/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ 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

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,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. An onsite follow-up visit was completed on	{2 000}	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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 January 19, 2017. During this onsite visit it was determined not all licensing orders were corrected as found on this State Form along with corrected licensing orders found on the CMS2567B. These uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings: Based on interview and record review, the facility	{21375}	1. Corrective Action: A. R40 an R2, nursing staff educated on Infection Control Program/Policy in	1/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21375}	Continued From page 2 failed to operationalize their infection control program/policy in regards to completing the resolution for Urinary Tract Infections (UTIs) for 2 of 4 residents (R40 and R2) reviewed who experienced UTIs. Findings included: The facility's Monthly Infection Control Reports and Monthly Infection Logs were requested and provided on 1/19/17 from 12/2016 and 1/2017 logs. The following was included on these logs: 12/2016 there were 3 infections with two being UTIs 1/2017 there were 6 infections with three being UTIs and one kidney infection/UTI. The logs lacked the date and resolution the UTIs had resolved. R40's progress notes and medication administration record (MAR) identified on 12/29/16 that R40 had not felt well, had emesis. On 1/6/17 note R40's catheter needed to be changed due to sediment in tubing, additional 300 millimeters of dark urine output noted thick sediment. Note dated 1/7/17 included R40 had no urine output for 16 hours after a second catheter change, had been sent to emergency room (ER). Returned with diagnosis of pyelonephritis (kidney infection) new order for Bactrim DS 800 mg/160 mg twice daily for five days. Note dated 1/8/17 R40 had temperature of 101.2 degrees Fahrenheit, urine output 75 milliliters by 2 p.m., at 3:30 p.m. blood coming from tip of penis, sent to ER at 4:45 p.m. and received an order to increase fluids. Return from ER with diagnosis of dehydration and UTI continue with antibiotic. Completion of antibiotic was 1/12/17. R40's record failed to have documentation of resolution	{21375}	regards to completing the resolution of UTI's. B. St. Mark's Nursing staff and Nurse Managers educated on Infection Control Program/Policy for antibiotic use and charting for resolution of signs and symptoms. 2. Corrective Action as it applies to other Residents: A. Will review Infection Control Program related to antibiotic use and the need for follow up charting once resident has completed the course of antibiotics for all residents at POC meeting, January 31st, 2017 B. All Nursing staff will be educated on charting following the use of antibiotic use and signs and symptoms resolved. C. In PCC an area has been added for reminder for nurses to chart on follow up antibiotic use for residents. 3. Date of Completion: January 26th, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting, January, 31st, 2017 B. Audits will be completed monthly and results discussed at weekly Risk Management meetings 5. Correction will be monitored by: A. Staff Developer/Infection Control RN and DON B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ________ B. WING ________	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21375}	Continued From page 3 of UTI after the completion of the antibiotic. R2's progress notes and medication administration record (MAR) identified on 12/29/16, R2 had been sent to Urology for a urinary catheter change, order to start three days of Ciprofloxacin 500 mg twice daily for three days. Note dated 12/30/16 R2 had been sent to ER for left sided weakness and difficult to arouse. Note dated 12/31/16, R2 returned with diagnosis of stroke and UTI. Given dose of Cednifir (antibiotic) 600 milligrams in the ER and to continue dose of 300 mg twice daily for seven days. Note dated 1/4/17 included the lab called facility and R2 had culture results of E. Coli. The MAR reads continued with both antibiotics of ciprofloxacin and cednifir. Completion of Antibiotic regime was on 1/7/17. However, R2's record failed to have resolution of the UTI after completion of the two antibiotic. On 1/19/17 at 2:36 p.m., registered nurse (RN)-B stated she was responsible for the infection control (IC) program. RN-B stated that she has been working on the program and trying to get it "straightened out" since last survey visit (exit on 11/17/16). RN-B stated they had included the need to document the resolution of signs and symptoms after the completion of the antibiotic for UTIs. RN-B verified resolution of UTIs had not been documented for either R40 or R2. On 1/19/17 at 4:51 p.m. Director of Nursing said she expected staff to follow the infection policy, which includes monitoring of resident to determine if antibiotic was affective and on completion of antibiotic use to document resolution of UTIs. And if no resolution to notify the doctor.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ______ B. WING ______	R 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21375}	Continued From page 4	{21375}		

The facility policy Infection Control Surveillance, dated 2/16, indicated:
Procedure: Documentation in the clinical record occurs at least daily in the presence or absence of symptoms until 48 hours after the symptoms or until 48 hours after the last dose of antibiotics.

This uncorrected order will remain in effect and will be reviewed at the next onsite visit. Also this uncorrected order will be reviewed for possible penalty assessments.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00394 Y1	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 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265 Reg. # MN Rule 4658.0085 LSC	Correction Completed 12/27/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 12/27/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 01/19/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 1/25/2017	SIGNATURE OF SURVEYOR 31221	DATE 1/19/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5S8S
Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245369**

2. STATE VENDOR OR MEDICAID NO. (L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LUTHERAN HOME**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 12/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
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 d*eficiencies 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	**11/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5369059 was completed. The complaint was not substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		12/27/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of a decline in health status in regards to congestive heart failure and weight gain following hospitalization for 1 of 1 resident (R99) whose death record was reviewed. Findings include: R99 was admitted to the nursing facility on 10/12/16, from a local hospital with diagnoses including: weakness, dehydration, acute/chronic kidney injury, and history of a gastrointestinal bleed. R99's admission Minimum Data Set (MDS) dated 10/19/16, identified R99 had intact 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.	F 157	1. Corrective Action: A. Resident R 99, Staff educated on change of Acute Condition Policy and proper steps taken to inform physician, family and resident B. St. Mark□s Living will notify the individuals necessary if there is a room change or roommate assignment C. St. Mark□s Living will periodically update resident□s contact information and legal representatives 2. Corrective Action as it applies to other Residents: A. Will review Acute changes Policy for all residents at POC meeting Dec 20th, 2016 B. All staff who deal directly with resident□s notification will be educated on any changes to resident□s room change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _______ B. WING _______	11/17/2016

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F 157	Continued From page 2 Interventions included: Daily weights, monitor pedal edema, vital signs weekly, notify MD (medical doctor) of significant abnormalities, monitor and document as needed changes in lung sounds on auscultation, edema and 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 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 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 not 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	F 157	or roommates C. Staff responsible for periodic updating of resident information will be educated 3. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting December 20th, 2016 B. Audits will be completed monthly and results discussed at weekly risk Management meetings C. Staff will inform resident and individual□s necessary to the resident of any changes in room or roommates 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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F 157	Continued From page 3	F 157		

inspiratory wheezes, lower lobe diminished breath 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 continue to keep her updated on R99's condition.

On 11/1/16, an interdisciplinary team (IDT) meeting note identified R99 had been noted to have 3+ edema in her lower extremities over the weekend, had a 10 lb weight gain, and had utilized the torsemide. The IDT note also indicated the occupational therapist was going to hold the lymphedema treatment until her fluid overload was back in line. There was no indication the physician or the NP-A had been notified of the weight gain.

The electronic medication administration record identified R99 had received torsemide three consecutive days on 10/31/16, 11/1/16, and 11/2/16 due to weight gain. There was no indication the facility had assessed R99's pulmonary status as part of the assessment, nor had they updated the physician about R99's 10 pound weight gain and subsequent use of torsemide.

Further record review indicated R99 had experienced an increase in behaviors. Nursing notes documented 11/2/16 at 1:05 p.m. indicated R99 was yelling out, attempting to strike out at staff, and was very demanding. The note indicated as long as staff remained in R99's room, she was calm but when staff started to leave her room she would yell out help. The note

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F 157	Continued From page 4	F 157		

indicated the resident stated she was "coughing up phlegm" and indicated this was the first time staff had seen an "increase in anxiety and behaviors." Again there was no indication the physician or the NP-A had been updated as to the increase in anxiety, behaviors indication oxygen hunger.

An entry in the EMR dated 11/2/16 at 1:57 p.m., indicated R99 had been speaking to the chaplain and was upset. The note indicated the resident had stated she could not breathe and "they don't believe me." According to the EMR note, an aide, the Chaplain, and the social worker talked with the resident and tried to comfort her. The note indicated: "Resident was asking for her doctor and stated that he was going to come again today" and indicated the resident's oxygen levels had been checked and the nursing assistant had increased the oxygen at the nurse's request. Again no timely notification of the physician or NP-A in regards to having difficulty breathing.

Another EMR entry from 2:02 p.m. 11/2/16, indicated: "[family member's name (FM-A)] gave verbal ok over the phone to transfer resident to ER (emergency room) for eval and treatment." At 7:03 p.m. on 11/2/16, there was an entry in the EMR that indicated R99 had been transferred from the local hospital to St. Mary's Hospital in Rochester due requiring a higher level of care due to pulmonary edema. The resident's record was reviewed further, and there was no documentation found to indicate the facility had contacted the physician regarding R99's weight gain, anxiety, breathing difficulty and pulmonary status. Instead, the facility staff had contacted the family to obtain permission to send R99 to the emergency room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING ______ B. WING ______	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5	F 157		

An entry in the EMR dated 11/7/16, indicated FM-A had notified the nursing home that R99 died on 11/6/16.

During an interview with the registered nurse (RN-M) manager on 11/16/16 at 2:43 p.m., RN-M stated she had been aware R99 was having trouble breathing, had anxiety and had lower extremity edema. RN-M stated she had assessed R99 and had subsequently provided direction to the licensed practical nurse (LPN) to call the family for permission to transfer R99 to the emergency room. When asked whether she had notified the physician prior to transfer, RN-M said she had not contacted the resident's physician because it could have taken a "day and a half for them to call back." Review of the EMR failed to include any documented assessment of R99's condition prior to her being sent to the hospital.

On 11/16/16 at 2:31 p.m., the licensed social worker (LSW) was interviewed. The LSW recalled having been in R99's room with an unknown nursing assistant (NA) and the chaplain. The LSW stated R99 had been hallucinating the weekend before however, there was no documentation of any hallucinations in the EMR. The LSW stated R99 had been very scared and agitated which she thought had caused R99 to become short of breath.

When interviewed on 11/16/16 at 3:32 p.m., the director of nursing (DON) stated R99 should have been weighed daily and the expectation for an admission weight was that it would be obtained within the first 24 hours from admission. The DON confirmed the lack of weights had been identified by RN-M.

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F 157	Continued From page 6 A request was made for a policy related to status change and was not provided. An undated policy, for "weights" was reviewed. The policy did not address the nursing facility's process for obtaining weights.	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess and implement interventions to treat fluid retention for 1 of 1 resident (R99) whose death record was reviewed. The facility's failure to provide adequate assessment and intervention resulted in harm for R99 who suffered anxiety and difficulty breathing requiring subsequent hospitalization. Findings include: R99 was admitted to the nursing facility on 10/12/16, from a local hospital with diagnoses including: weakness, dehydration, acute/chronic kidney injury, and history of a gastrointestinal bleed. R99's admission Minimum Data Set (MDS) dated 10/19/16, identified R99 had intact cognition and was able to verbalize her needs. R99's care plan dated 10/12/16, indicated	F 309	1. Corrective Action: A. Resident R 99, staff educated on Change of Acute Condition Policy and proper steps taken to inform physician, family and resident B. Nursing staff and Nurse Managers educated on change of Acute Condition Changes- clinical protocol 2. Corrective Action as it applies to other Residents: A. Will review Acute changes Policy for all residents at POC meeting December 20th, 2016 B. All Nursing staff will be educated on monitoring for acute changes per policy C. Nursing staff educated on steps needed to inform those necessary	12/27/16

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F 309	Continued From page 7 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 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 three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep oxygen (O2) saturations greater than 90 percent (%). Although R99 had been admitted to the facility on 10/12/16, the first weight completed was on 10/20/16 (eight days after admission), and was documented as 95.9 lbs found in the weight section of the electronic medical records (EMR). While the admission orders from the hospital and included on R99's comprehensive care plan included weights should be monitored daily, there were only three additional weights documented after 10/20/16: 10/31/16: 108 lbs. 11/1/16: 105 lbs. 11/2/16 105.8 lbs A nursing progress note documented on 10/25/16 at 12:54 p.m., identified R99 had been admitted	F 309	individuals 2. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting December 20th, 2016 B. Audits will be completed monthly and results discussed at weekly risk Management meetings 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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for rehabilitation, and continued to receive therapy services. The note identified limitation with activities of daily living, ambulation and deconditioning which required rest periods for therapy. The progress noted did not include any documented concerns related to the resident's breathing, pulmonary status, weight gain or edema.
A nurse's note documented in the EMR dated 10/31/16, indicated a message had been sent to the nurse practitioner (NP)-A at the local clinic, regarding R99's having inspiratory wheezes, lower lobe diminished breath sounds, and three plus pitting edema. The note did not indicate the NP-A had been informed of R99's weight gain of 12 pounds from 10/20/16 weight 95.9 lb and on 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 continue to keep her updated on R99's condition.

On 11/1/16, an interdisciplinary team (IDT) meeting note identified R99 had been noted to have 3+ edema in her lower extremities over the weekend, had a 10 lb weight gain, and had utilized the torsemide (diuretic). The IDT note also indicated the occupational therapist was going to hold the lymphedema treatment until her fluid overload was back in line.

The electronic medication administration record identified R99 had received torsemide for three consecutive days on 10/31/16, 11/1/16, and 11/2/16 due to weight gain. However, there was no indication the facility had fully assessed R99's pulmonary status (breathing) as part of the overall health assessment especially with the over 10 pound weight gain in one day, nor had they

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updated the physician/NP-A about R99's 10 pound weight gain and subsequent use of torsemide.

Further record review indicated R99 had experienced an increase in anxiety behaviors. Nursing notes documented 11/2/16 at 1:05 p.m. indicated R99 was yelling out, attempting to strike out at staff, and was very demanding. The note indicated as long as staff remained in R99's room, she was calm but when staff started to leave her room she would yell out for help. The note indicated the resident stated she was "coughing up phlegm" and indicated this was the first time staff had seen an "increase in anxiety and behaviors."

An entry in the EMR dated 11/2/16 at 1:57 p.m., indicated R99 had been speaking to the chaplain and was upset. The note indicated during the visit the resident had stated she could not breathe and "they don't believe me." According to the EMR note, an aide, the Chaplain, and the facility social worker talked with the resident and tried to comfort her. The note indicated: "Resident was asking for her doctor and stated that he was going to come again today" and indicated the resident's oxygen levels had been checked and the nursing assistant had increased the oxygen level at the nurse's request.

Another EMR entry dated 11/2/16 at 2:02 p.m. indicated: "[family member (FM)-A] gave a verbal ok over the phone to transfer resident to ER [emergency room] for eval and treatment." On 11/2/16 at 7:03 p.m. there was an entry in the EMR that indicated R99 had been transferred from the local hospital to St. Mary's Hospital in Rochester due to requiring a higher level of care

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due to pulmonary edema. The resident's record was reviewed further, and there was no documentation found to indicate the facility had contacted the physician regarding R99's weight gain, increased anxiety, breathing difficulty and decline in pulmonary status. Even though there was an admission order to do so. Instead, the facility staff had contacted the family to obtain permission to send R99 to the emergency room.

An entry in the EMR dated 11/7/16, indicated FM-A had notified the nursing home that R99 died on 11/6/16.

During an interview with the registered nurse (RN)-M a manager on 11/16/16 at 2:43 p.m., RN-M stated she had been aware R99 was having trouble breathing, had anxiety and had lower extremity edema. RN-M stated she had assessed R99 and had subsequently provided direction to the licensed practical nurse (LPN) to call the family for permission to transfer R99 to the emergency room. When asked whether she had notified the physician prior to transfer, RN-M said she had not contacted the resident's physician because it could have taken a "day and a half for them to call back." Review of the EMR failed to include any documented assessment of R99's condition prior to her being sent to the hospital.

During the interview with RN-M at 2:43 p.m. on 11/16/16, RN-M confirmed R99's admission date, and verified a weight had not been documented until the 8th day after admission even though R99 was supposed to have been weighed daily. RN-M said when she had realized R99 had not been weighed per protocol, she said she immediately educated all day shift nursing staff because the

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F 309	Continued From page 11 weights are done on the day shift. RN-M stated she was monitoring this process. The education was documented with staff signatures to confirm the nurses had received training per the RNM. On 11/16/16 at 3:30 p.m. a phone message was left for the LPN to return a call for an interview with no return call. On 11/16/16 at 2:31 p.m., the licensed social worker (LSW) was interviewed. The LSW recalled having been in R99's room with an unknown nursing assistant (NA) and the chaplain. The LSW stated R99 had been hallucinating the weekend before however, there was no documentation of any hallucinations in the EMR. The LSW stated R99 had been very scared and agitated which she thought had caused R99 to become short of breath. When interviewed on 11/16/16 at 3:32 p.m., the director of nursing (DON) stated R99 should have been weighed daily and the expectation for an admission weight was that it would be obtained within the first 24 hours from admission. The DON confirmed the lack of weights had been identified by RN-M and as a result staff education had been provided and monitoring of weights had been implemented. A request was made for a policy related to status change and was not provided. An undated policy, for "weights" was reviewed. The policy did not address the nursing facility's process for obtaining weights.	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		12/27/16

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F 356	Continued From page 12 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently include accurate nursing hours worked on the daily nursing hour posting. This had the potential to affect all 57 residents residing at the facility as well as family/visitors.	F 356	1. Corrective Action: A. Facility will post accurate daily nursing hours B. Full shifts and half shifts will be included on daily census sheets for all nursing hours	

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F 356	Continued From page 13 Findings include: During observations on 11/15/16 and 11/16/16 the facility nursing hour posting did not have the correct actual hours/shifts worked for the registered nurse (RN), licensed practical nurse (LPN), trained medical assistant (TMA) and nursing assistance (NA). Inaccurate posting of the nursing hours worked are listed below: Hours of shift posted vs. actual hours: 11/14/16- 1 NA shift posted for hours 6:00 a.m.-11:00 a.m. (5 hours) vs. actual hours of shift-6:00 a.m.-2:00 p.m. (8 hours); and 1 NA shift posted for the shift identified as 2:00 p.m.-10:00 p.m.(8 hours) vs. the actual shift hours hours of shift-2:00 p.m.-8:00 p.m. (6 hours). 11/15/16-1 NA shift posted for the hours 2:00 p.m.-10:00 p.m. (8 hours) vs. the actual shift hours 2:00 p.m.-8:00 p.m. (6 hours). 11/16/16-1 NA shift posted for the hours 2:00 p.m.-10:00 p.m. (8 hours) vs. the actual shift hours 2:00 p.m.-8:00 p.m. (6 hours); and 1 NA shift posted for the hours 2:00 p.m.-10:00 p.m. (8 hours) vs. the actual shift hours 4:00 p.m.-10:00 p.m. (6 hours). Interview with the facility staffing scheduler and director of nursing on 11/17/16, at 12:00 p.m. confirmed the facility daily nursing hour posting had inaccurate actual nursing hours/shifts worked each day as listed above.	F 356	2. 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 2. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Proper posting of accurate daily nursing hours for all shifts worked including half shifts. B. Audits will be completed weekly and results discussed at QAPI 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		12/27/16

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F 441	Continued From page 14 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 441	1. Corrective Action:	

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F 441	Continued From page 15 failed to maintain an infection control program that tracked and analyzed infection patterns and trends, failed to identify recurrent urinary tract infections (UTI's), failed to obtain culture results and document resolution for UTI's for 5 of 5 residents (R11, R74, R43, R36, R22) reviewed who experienced UTI's. Findings included: Tracking and Analysis of Infections The facility' s Monthly Infection Control Reports and Monthly Infection Logs were obtained from 1/16 through 10/16. The monthly records identified the following: -1/16: 6 infections (3-UTI's); -2/16: 4 UTI's; -3/16: 8 infections (6 were UTI's); -4/16: 3 infections (1 was UTI's); -5/16: 8 infections (6 were UTI's); 1 did not identify the type of infection; -6/16: No reports or logs available; -7/16: 7 infections (6 were UTI's); -8/16: 7 infections (4 were UTI; 1 was urosepsis of the 4); -9/16: 4 infections (3 were UTI's); -10/16: 11 infections (7 were UTI's). The records lacked the following: tracking of infections for the month of June 2016, identification whether the infections were in house and/or community acquired, date resolved and consistent documentation of signs and symptoms, culture results and date onset. The facility provided the following information: nursing assistant meeting dated 5/19/16, included education of UTI's and catheter care handouts and video and nurse's meeting agenda on	F 441	A. St. Mark□s Living 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 B. St. Mark□s Living will Prevent the spread of infections by: " Determining the proper need for isolation to prevent the spread of infection " Prohibit employees with communicable disease or infected skin lesions from direct contact with residents and their food if direct contact will spread the disease " St. Marks□s 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. 2. Corrective Action as it applies to other Residents: A. St. Mark□s will establish an infection control program for all residents that prevents the spread of infections as stated above B. Nursing staff and environmental staff will be educated on infection control program at POC meeting December 20th, 2016 2. Date of Completion: December 27th, 2016 3. Reoccurrence will be prevented by:	

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F 441	Continued From page 16 8/24/16, included infection control issue, UTI's, hand hygiene and glove use. Nursing assistant meeting 8/24/16, included infection control issues hand hygiene and glove use. In addition, the records failed to include an analysis of infections, which included identification of outbreaks of infection as well as implementing and documenting actions to resolve related problems. UTI Monitoring (Culture Results and Resolution) R11's progress notes and medication administration record (MAR) identified the following: -7/28/16, complains vaginal pain. 7/30/16 complains back pain, intense burning with urination and foul smelling urine. 7/30/16, to emergency department (ED) and returned with diagnosis of UTI. Given dose IV (intravenous) Levaquin (antibiotic). Order for Levaquin 500 mg (milligrams) daily for five days. 8/1/16, received call to change antibiotic to Cefdiner due to being more effective on current infection. R11's MAR dated 7/16 and 8/16 identified the resident received Levaquin 500 mg daily on 7/31/16, 8/1/16 and Cefdinir 300 mg twice daily for 10 days, starting 8/2/16. R11 ' s record failed to include culture results and documentation of resolution of the UTI. -10/24/16, sent to ED, having hypoglycemic reactions. Returned with orders for antibiotic for UTI. 10/25/16, Cefdinir 300 mg two times a day times seven days. 10/26/16, on antibiotic for UTI. Temp 99.3. 10/27/16, continues on antibiotic for UTI. Temp 96.3. No complaints of any pain or discomfort. R11's MAR dated 10/16, identified R11 received Cefdinir 300 mg two times daily for seven days. R11's record failed to include culture	F 441	A. Nursing staff and environmental staff will be educated on Infection control program at POC meeting December 20th,2016 B. Records will indicate tracking of infections acquired by in house as well as analysis of infections C. Audits will be completed monthly and results discussed at QAPI. 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17	F 441		

results and documentation of resolution of the UTI.

R74's progress notes and medication administration record (MAR) identified the following:
-9/19/16 patient has not been herself, very slow in the morning to respond or eat. Order to send to ED. Returned from the hospital, new orders for UTI, Cipro 250 mg twice daily for seven days. R74's MAR dated 9/16 identified the resident received Cipro 250 mg two times a day for seven days. Documentation in R74's record lacked culture results and documentation of UTI resolution.

R43's progress notes and medication administration record (MAR) identified the following:
-7/6/16, confused and pulling at catheter stated needed to use the bathroom. Hospice wrote orders for acquire urine culture and page Hospice with results. Urine obtained and sent to lab for evaluation. 7/7/16 urine results, Cipro 250 mg twice daily for 10 days. 7/9/16 follow up urine 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

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	245369	A. BUILDING ______ B. WING ______	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LUTHERAN HOME	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

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F 441	Continued From page 18	F 441		

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 4 times/day for 7 days for UTI. R36's MAR dated 9/16 identified R36 received 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 left with left arm hanging down, upon observation left side facial droop, left facility via stretcher. Nurse called emergency room, resident will be sent back. They stated urine had slight trace bacteria and were going to start resident on Levaquin and they administered R22 IV dose and returned with orders for Levaquin 750 mg daily for 5 days. 7/1/16 discontinue Levaquin and start Macrobid 100 mg twice daily for 7 days. Review of the June MAR identified R22 received Levaquin and Macrobid as ordered. R22's record failed to include culture results and documentation of resolution of the UTI.

On 11/17/16, at 12:06 p.m., registered nurse (RN)-C stated she was responsible for the infection control (IC) program, starting with infection control monitoring April 2016 and was

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	245369	A. BUILDING ______ B. WING ______	11/17/2016

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F 441	Continued From page 19 absent for the months of July and August. She explained that during her absence the director of nursing (DON) was responsible for the IC monitoring. RN-C verified tracking of infections did not include all required information and analysis of infections had not been documented. RN-C verified resolution of UTI's was not being documented. The facility policy Infection Control and Prevention Program, dated 5/11, indicated the facility develops, implements, maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Procedure: 1) A registered nurse is designated to serve as coordinator of the infection prevention and control program. The nurse is considered the facility's Infection Preventionist (IP). Staff are assigned to assist with infection control program, as needed. Duties of the IP may include but are not limited to: b) Overseeing staff/volunteer training on infection control policies and procedures upon hire, annually and as needed; d) Overseeing the tracking of infections, monthly infection reports, and reports for review by the Quality Assurance Committee; e) Collaborates with QA Committee to develop corrective action plans to respond to any errors, problems or other identified issues in the infection control and prevention program. F) Monitoring antibiotic use. The facility policy Infection Control Surveillance, dated 2/16, indicated: Policy: Signs and symptoms of infection are continually monitored. Purpose: To identify at onset so that appropriate treatment and infection control procedures can be	F 441		

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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 compilation of the infection data.	F 441		

T5369025

PRINTED: 12/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/17/2016**

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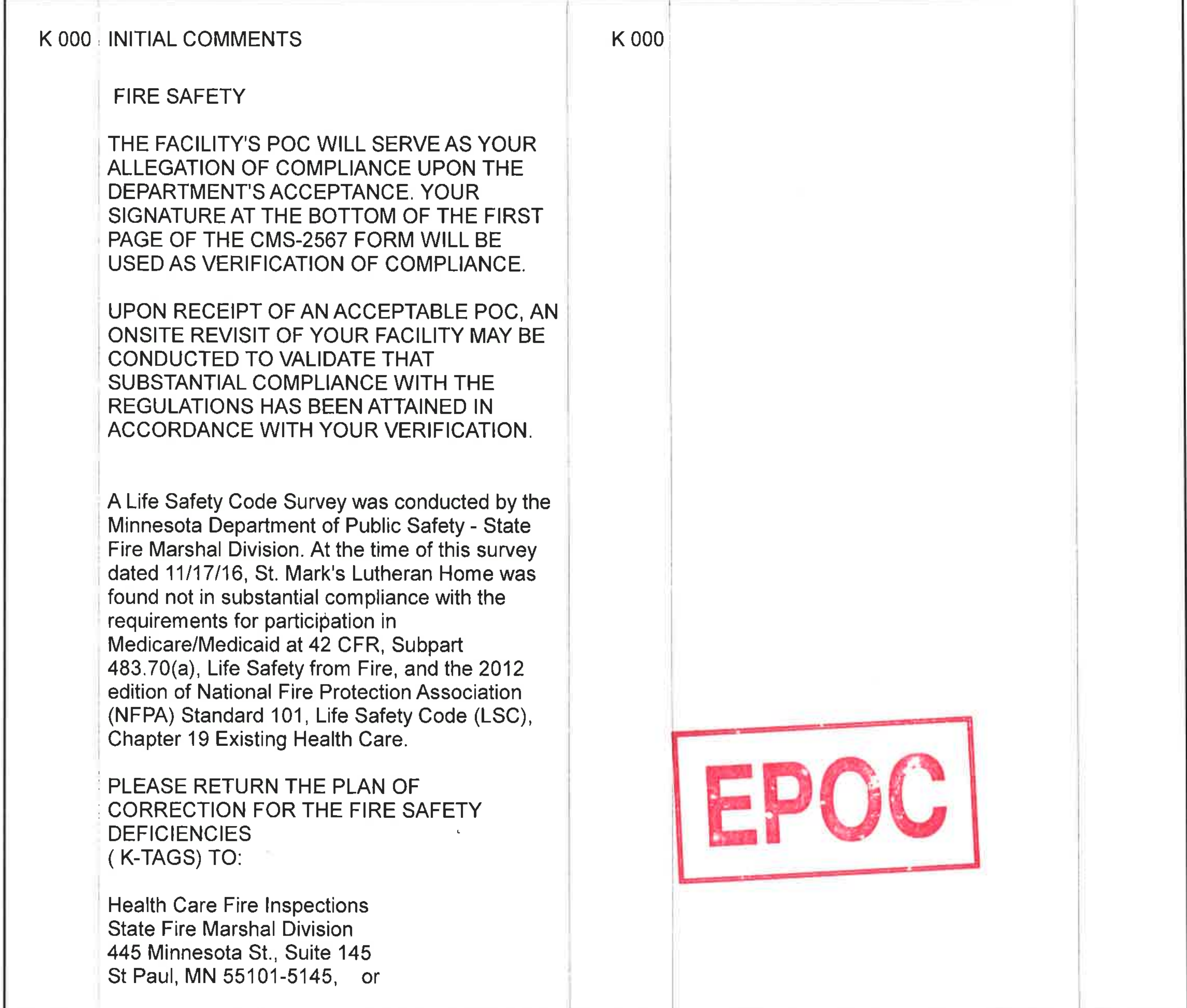
ST MARKS LUTHERAN HOME	**400 - 15TH AVENUE SOUTHWEST** **AUSTIN, MN 55912**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 11/17/16, St. Mark's Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING	11/17/2016

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility will be surveyed as one building per new 2012 Life Safety Code. St. Mark's Lutheran Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1967, addition was constructed to the East Wing that was determined to be of Type II(111) construction. In 1981, another addition was added to the East Wing and was determined to be Type V(111). In 1991, an addition was added to the North Wing and was determined to be Type II (111) construction. In 2013 another addition was a 1-story building with no basement. The 2013 addition was also determined to be of Type V (111) construction.

The building meets the construction type allowed for existing buildings, the facility was surveyed as a Type V (111) building.

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K 000	Continued From page 2 The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372	As of 11-18-2016 the penetrations around the sprinkler piping above the doors in Silver Maple and memory Care wings have been sealed with fire caulk. As of 11-23-2016 all smoke barrier and fire separation walls have been checked for penetrations that are not fire caulked.	12/22/16

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

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K 372	Continued From page 3 Describe any mechanical smoke control system in REMARKS. On facility tour between 09:00 AM and 01:00 PM on Nov. 17, 2016, based on observation and interview revealed that the findings include: 1.Penetrations around fire sprinkler piping were found in the smoke barrier walls above doors in Silver Maple wing and Memory care wing. Check all smoke barrier and fire separations walls for penetrations. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ________ B. WING ________	11/17/2016

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ST MARKS LUTHERAN HOME	**400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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

Electronically Signed | 12/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 15, 16, & 17, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, a complaint investigation was also completed at the time of the licensing survey. An investigation of complaint H5369059 was completed. The complaint was not substantiated.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		12/27/16

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ST MARKS LUTHERAN HOME	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of a decline in health status in regards to congestive heart failure and weight gain following hospitalization for 1 of 1 resident (R99) whose death record was reviewed. Findings include: R99 was admitted to the nursing facility on 10/12/16, from a local hospital with diagnoses including: weakness, dehydration, acute/chronic kidney injury, and history of a gastrointestinal bleed. R99's admission Minimum Data Set (MDS) dated 10/19/16, identified R99 had intact 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 MD (medical doctor) of significant abnormalities, monitor and document as needed changes in lung sounds on auscultation, edema and 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 color/warmth of extremities.	2 265	1. Corrective Action: A. Resident R 99, Staff educated on change of condition policy and proper steps taken to inform physician, family and resident B. Nurses and Nurse Managers educated on change of Acute Condition Changes- clinical protocol 2. Corrective Action as it applies to other Residents: A. will review Acute changes Policy for all residents at POC meeting B. all Nursing staff will be educated on monitoring for acute changes and steps needed to inform those necessary 3. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting B. Audits will be completed monthly and results discussed at weekly risk Management meetings 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: ______ B. WING ______	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	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 not 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 breath 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 continue to keep her updated on R99's condition. On 11/1/16, an interdisciplinary team (IDT)	2 265		

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2 265	Continued From page 5	2 265		

meeting note identified R99 had been noted to have 3+ edema in her lower extremities over the weekend, had a 10 lb weight gain, and had utilized the torsemide. The IDT note also indicated the occupational therapist was going to hold the lymphedema treatment until her fluid overload was back in line. There was no indication the physician or the NP-A had been notified of the weight gain.

The electronic medication administration record identified R99 had received torsemide three consecutive days on 10/31/16, 11/1/16, and 11/2/16 due to weight gain. There was no indication the facility had assessed R99's pulmonary status as part of the assessment, nor had they updated the physician about R99's 10 pound weight gain and subsequent use of torsemide.

Further record review indicated R99 had experienced an increase in behaviors. Nursing notes documented 11/2/16 at 1:05 p.m. indicated R99 was yelling out, attempting to strike out at staff, and was very demanding. The note indicated as long as staff remained in R99's room, she was calm but when staff started to leave her room she would yell out help. The note indicated the resident stated she was "coughing up phlegm" and indicated this was the first time staff had seen an "increase in anxiety and behaviors." Again there was no indication the physician or the NP-A had been updated as to the increase in anxiety, behaviors indication oxygen hunger.

An entry in the EMR dated 11/2/16 at 1:57 p.m., indicated R99 had been speaking to the chaplain and was upset. The note indicated the resident had stated she could not breathe and "they don't

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2 265	Continued From page 6 believe me." According to the EMR note, an aide, the Chaplain, and the social worker talked with the resident and tried to comfort her. The note indicated: "Resident was asking for her doctor and stated that he was going to come again today" and indicated the resident's oxygen levels had been checked and the nursing assistant had increased the oxygen at the nurse's request. Again no timely notification of the physician or NP-A in regards to having difficulty breathing. Another EMR entry from 2:02 p.m. 11/2/16, indicated: "[family member's name (FM-A)] gave verbal ok over the phone to transfer resident to ER (emergency room) for eval and treatment." At 7:03 p.m. on 11/2/16, there was an entry in the EMR that indicated R99 had been transferred from the local hospital to St. Mary's Hospital in Rochester due requiring a higher level of care due to pulmonary edema. The resident's record was reviewed further, and there was no documentation found to indicate the facility had contacted the physician regarding R99's weight gain, anxiety, breathing difficulty and pulmonary status. Instead, the facility staff had contacted the family to obtain permission to send R99 to the emergency room. An entry in the EMR dated 11/7/16, indicated FM-A had notified the nursing home that R99 died on 11/6/16. During an interview with the registered nurse (RN-M) manager on 11/16/16 at 2:43 p.m., RN-M stated she had been aware R99 was having trouble breathing, had anxiety and had lower extremity edema. RN-M stated she had assessed R99 and had subsequently provided direction to the licensed practical nurse (LPN) to call the family for permission to transfer R99 to the	2 265		

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2 265	Continued From page 7 emergency room. When asked whether she had notified the physician prior to transfer, RN-M said she had not contacted the resident's physician because it could have taken a "day and a half for them to call back." Review of the EMR failed to include any documented assessment of R99's condition prior to her being sent to the hospital. On 11/16/16 at 2:31 p.m., the licensed social worker (LSW) was interviewed. The LSW recalled having been in R99's room with an unknown nursing assistant (NA) and the chaplain. The LSW stated R99 had been hallucinating the weekend before however, there was no documentation of any hallucinations in the EMR. The LSW stated R99 had been very scared and agitated which she thought had caused R99 to become short of breath. When interviewed on 11/16/16 at 3:32 p.m., the director of nursing (DON) stated R99 should have been weighed daily and the expectation for an admission weight was that it would be obtained within the first 24 hours from admission. The DON confirmed the lack of weights had been identified by RN-M. A request was made for a policy related to status change and was not provided. An undated policy, for "weights" was reviewed. The policy did not address the nursing facility's process for obtaining weights. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures related to how to assess resident medical conditions, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures.	2 265		

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2 265	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess and implement interventions to treat fluid retention for 1 of 1 resident (R99) whose death record was reviewed. The facility's failure to provide adequate assessment and intervention resulted in harm for R99 who suffered anxiety and difficulty breathing requiring subsequent hospitalization. Findings include: R99 was admitted to the nursing facility on 10/12/16, from a local hospital with diagnoses including: weakness, dehydration, acute/chronic kidney injury, and history of a gastrointestinal bleed. R99's admission Minimum Data Set (MDS) dated 10/19/16, identified R99 had intact	2 830	1. Corrective Action: A. Resident R 99, Staff educated on change of Acute Condition Policy and proper steps taken to inform physician, family and resident B. Nursing staff and Nurse Managers educated on change of Acute Condition Changes- clinical protocol 2. Corrective Action as it applies to other Residents: A. Will review Acute changes Policy for all residents at POC meeting B. All Nursing staff will be educated on monitoring for acute changes and steps needed to inform those necessary 3. Date of Completion: December	12/27/16

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2 830	Continued From page 9 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 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 three days, or pedal edema. The physician had also ordered continuous oxygen via nasal cannula 1 liter, to keep oxygen (O2) saturations greater than 90 percent (%). Although R99 had been admitted to the facility on 10/12/16, the first weight completed was on 10/20/16 (eight days after admission), and was documented as 95.9 lbs found in the weight section of the electronic medical records (EMR). While the admission orders from the hospital and included on R99's comprehensive care plan included weights should be monitored daily, there were only three additional weights documented after 10/20/16: 10/31/16: 108 lbs. 11/1/16: 105 lbs. 11/2/16 105.8 lbs A nursing progress note documented on 10/25/16	2 830	27th, 2016 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting B. Audits will be completed monthly and results discussed at weekly risk Management meetings 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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2 830	Continued From page 10	2 830		

at 12:54 p.m., identified R99 had been admitted for rehabilitation, and continued to receive therapy services. The note identified limitation with activities of daily living, ambulation and deconditioning which required rest periods for therapy. The progress noted did not include any documented concerns related to the resident's breathing, pulmonary status, weight gain or edema.
A nurse's note documented in the EMR dated 10/31/16, indicated a message had been sent to the nurse practitioner (NP)-A at the local clinic, regarding R99's having inspiratory wheezes, lower lobe diminished breath sounds, and three plus pitting edema. The note did not indicate the NP-A had been informed of R99's weight gain of 12 pounds from 10/20/16 weight 95.9 lb and on 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 continue to keep her updated on R99's condition.

On 11/1/16, an interdisciplinary team (IDT) meeting note identified R99 had been noted to have 3+ edema in her lower extremities over the weekend, had a 10 lb weight gain, and had utilized the torsemide (diuretic). The IDT note also indicated the occupational therapist was going to hold the lymphedema treatment until her fluid overload was back in line.

The electronic medication administration record identified R99 had received torsemide for three consecutive days on 10/31/16, 11/1/16, and 11/2/16 due to weight gain. However, there was no indication the facility had fully assessed R99's pulmonary status (breathing) as part of the overall health assessment especially with the over 10 pound weight gain in one day, nor had they

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2 830	Continued From page 11	2 830		

updated the physician/NP-A about R99's 10 pound weight gain and subsequent use of torsemide.

Further record review indicated R99 had experienced an increase in anxiety behaviors. Nursing notes documented 11/2/16 at 1:05 p.m. indicated R99 was yelling out, attempting to strike out at staff, and was very demanding. The note indicated as long as staff remained in R99's room, she was calm but when staff started to leave her room she would yell out for help. The note indicated the resident stated she was "coughing up phlegm" and indicated this was the first time staff had seen an "increase in anxiety and behaviors."

An entry in the EMR dated 11/2/16 at 1:57 p.m., indicated R99 had been speaking to the chaplain and was upset. The note indicated during the visit the resident had stated she could not breathe and "they don't believe me." According to the EMR note, an aide, the Chaplain, and the facility social worker talked with the resident and tried to comfort her. The note indicated: "Resident was asking for her doctor and stated that he was going to come again today" and indicated the resident's oxygen levels had been checked and the nursing assistant had increased the oxygen level at the nurse's request.

Another EMR entry dated 11/2/16 at 2:02 p.m. indicated: "[family member (FM)-A] gave a verbal ok over the phone to transfer resident to ER [emergency room] for eval and treatment." On 11/2/16 at 7:03 p.m. there was an entry in the EMR that indicated R99 had been transferred from the local hospital to St. Mary's Hospital in Rochester due to requiring a higher level of care due to pulmonary edema. The resident's record

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2 830	Continued From page 12	2 830		

was reviewed further, and there was no documentation found to indicate the facility had contacted the physician regarding R99's weight gain, increased anxiety, breathing difficulty and decline in pulmonary status. Even though there was an admission order to do so. Instead, the facility staff had contacted the family to obtain permission to send R99 to the emergency room.

An entry in the EMR dated 11/7/16, indicated FM-A had notified the nursing home that R99 died on 11/6/16.

During an interview with the registered nurse (RN)-M a manager on 11/16/16 at 2:43 p.m., RN-M stated she had been aware R99 was having trouble breathing, had anxiety and had lower extremity edema. RN-M stated she had assessed R99 and had subsequently provided direction to the licensed practical nurse (LPN) to call the family for permission to transfer R99 to the emergency room. When asked whether she had notified the physician prior to transfer, RN-M said she had not contacted the resident's physician because it could have taken a "day and a half for them to call back." Review of the EMR failed to include any documented assessment of R99's condition prior to her being sent to the hospital.

During the interview with RN-M at 2:43 p.m. on 11/16/16, RN-M confirmed R99's admission date, and verified a weight had not been documented until the 8th day after admission even though R99 was supposed to have been weighed daily. RN-M said when she had realized R99 had not been weighed per protocol, she said she immediately educated all day shift nursing staff because the weights are done on the day shift. RN-M stated she was monitoring this process. The education

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2 830	Continued From page 13	2 830		

was documented with staff signatures to confirm the nurses had received training per the RNM.

On 11/16/16 at 3:30 p.m. a phone message was left for the LPN to return a call for an interview with no return call.

On 11/16/16 at 2:31 p.m., the licensed social worker (LSW) was interviewed. The LSW recalled having been in R99's room with an unknown nursing assistant (NA) and the chaplain. The LSW stated R99 had been hallucinating the weekend before however, there was no documentation of any hallucinations in the EMR. The LSW stated R99 had been very scared and agitated which she thought had caused R99 to become short of breath.

When interviewed on 11/16/16 at 3:32 p.m., the director of nursing (DON) stated R99 should have been weighed daily and the expectation for an admission weight was that it would be obtained within the first 24 hours from admission. The DON confirmed the lack of weights had been identified by RN-M and as a result staff education had been provided and monitoring of weights had been implemented.

A request was made for a policy related to status change and was not provided.
An undated policy, for "weights" was reviewed. The policy did not address the nursing facility's process for obtaining weights.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could develop policies and procedures related to how to assess resident medical conditions, educate staff regarding these polices, and audit resident records for compliance to these policies and procedures.

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2 830	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to maintain an infection control program that tracked and analyzed infection patterns and trends, failed to identify recurrent urinary tract infections (UTI's), failed to obtain culture results and document resolution for UTI's for 5 of 5 residents (R11, R74, R43, R36, R22) reviewed who experienced UTI's. Findings included: Tracking and Analysis of Infections The facility' s Monthly Infection Control Reports and Monthly Infection Logs were obtained from 1/16 through 10/16. The monthly records identified the following: -1/16: 6 infections (3-UTI's); -2/16: 4 UTI's; -3/16: 8 infections (6 were UTI's); -4/16: 3 infections (1 was UTI's); -5/16: 8 infections (6 were UTI's); 1 did not identify the type of infection; -6/16: No reports or logs available; -7/16: 7 infections (6 were UTI's);	21375	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 infection " Prohibit employees with communicable disease or infected skin lesions from direct contact with residents and their food if direct contact will spread the disease " St. Marks□s 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.	12/27/16

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21375	Continued From page 15 -8/16: 7 infections (4 were UTI; 1 was urosepsis of the 4); -9/16: 4 infections (3 were UTI's); -10/16: 11 infections (7 were UTI's). The records lacked the following: tracking of infections for the month of June 2016, identification whether the infections were in house and/or community acquired, date resolved and consistent documentation of signs and symptoms, culture results and date onset. The facility provided the following information: nursing assistant meeting dated 5/19/16, included education of UTI's and catheter care handouts and video and nurse's meeting agenda on 8/24/16, included infection control issue, UTI's, hand hygiene and glove use. Nursing assistant meeting 8/24/16, included infection control issues hand hygiene and glove use. In addition, the records failed to include an analysis of infections, which included identification of outbreaks of infection as well as implementing and documenting actions to resolve related problems. UTI Monitoring (Culture Results and Resolution) R11's progress notes and medication administration record (MAR) identified the following: -7/28/16, complains vaginal pain. 7/30/16 complains back pain, intense burning with urination and foul smelling urine. 7/30/16, to emergency department (ED) and returned with diagnosis of UTI. Given dose IV (intravenous) Levaquin (antibiotic). Order for Levaquin 500 mg (milligrams) daily for five days. 8/1/16, received call to change antibiotic to Cefdiner due to being more effective on current infection. R11's MAR	21375	2. Corrective Action as it applies to other Residents: A. St. Mark□s will establish an infection control program for all residents that prevents the spread of infections B. Nursing staff will be educated on infection control program at POC meeting 3. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Nursing staff will be educated on Infection control program at POC meeting B. Records will indicate tracking of infections acquired by in house as well as analysis of infections C. Audits will be completed monthly and results discussed at QAPI. 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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21375	Continued From page 16	21375		

dated 7/16 and 8/16 identified the resident received Levaquin 500 mg daily on 7/31/16, 8/1/16 and Cefdinir 300 mg twice daily for 10 days, starting 8/2/16. R11 ' s record failed to include culture results and documentation of resolution of the UTI.
-10/24/16, sent to ED, having hypoglycemic reactions. Returned with orders for antibiotic for UTI. 10/25/16, Cefdinir 300 mg two times a day times seven days. 10/26/16, on antibiotic for UTI. Temp 99.3. 10/27/16, continues on antibiotic for UTI. Temp 96.3. No complaints of any pain or discomfort. R11's MAR dated 10/16, identified R11 received Cefdinir 300 mg two times daily for seven days. R11's record failed to include culture results and documentation of resolution of the UTI.

R74's progress notes and medication administration record (MAR) identified the following:
-9/19/16 patient has not been herself, very slow in the morning to respond or eat. Order to send to ED. Returned from the hospital, new orders for UTI, Cipro 250 mg twice daily for seven days. R74's MAR dated 9/16 identified the resident received Cipro 250 mg two times a day for seven days. Documentation in R74's record lacked culture results and documentation of UTI resolution.

R43's progress notes and medication administration record (MAR) identified the following:
-7/6/16, confused and pulling at catheter stated needed to use the bathroom. Hospice wrote orders for acquire urine culture and page Hospice with results. Urine obtained and sent to lab for evaluation. 7/7/16 urine results, Cipro 250 mg twice daily for 10 days. 7/9/16 follow up urine

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21375	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 4 times/day for 7 days for UTI. R36's MAR dated 9/16 identified R36 received 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 left with left arm hanging down, upon observation left side facial droop, left facility via stretcher. Nurse called emergency room, resident will be sent back. They stated urine had slight trace bacteria and were going to start	21375		

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21375	Continued From page 18 resident on Levaquin and they administered R22 IV dose and returned with orders for Levaquin 750 mg daily for 5 days. 7/1/16 discontinue Levaquin and start Macrobid 100 mg twice daily for 7 days. Review of the June MAR identified R22 received Levaquin and Macrobid as ordered. R22's record failed to include culture results and documentation of resolution of the UTI. On 11/17/16, at 12:06 p.m., registered nurse (RN)-C stated she was responsible for the infection control (IC) program, starting with infection control monitoring April 2016 and was absent for the months of July and August. She explained that during her absence the director of nursing (DON) was responsible for the IC monitoring. RN-C verified tracking of infections did not include all required information and analysis of infections had not been documented. RN-C verified resolution of UTI's was not being documented. The facility policy Infection Control and Prevention Program, dated 5/11, indicated the facility develops, implements, maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Procedure: 1) A registered nurse is designated to serve as coordinator of the infection prevention and control program. The nurse is considered the facility's Infection Preventionist (IP). Staff are assigned to assist with infection control program, as needed. Duties of the IP may include but are not limited to: b) Overseeing staff/volunteer training on infection control policies and procedures upon hire, annually and as needed; d) Overseeing the tracking of infections, monthly infection reports, and reports for review by the Quality Assurance	21375		

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21375	Continued From page 19 Committee; e) Collaborates with QA Committee to develop corrective action plans to respond to any errors, problems or other identified issues in the infection control and prevention program. F) Monitoring antibiotic use. The facility policy Infection Control Surveillance, dated 2/16, indicated: Policy: Signs and symptoms of infection are continually monitored. Purpose: To identify at onset so that appropriate treatment and infection control procedures can be 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 compilation of the infection data. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the need to follow the facility policy and procedure for a functioning infection program to prevent the spread of infections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		12/27/16

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21426	Continued From page 20 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 employees (E2, E3) had a tuberculosis (TB) symptom screening and two step tuberculosis skin test (TST) completed; failed to ensure 3 of 5 employees (E1, E4, E5) two step TST's included the times of administration and results read; failed to ensure 1 of 5 residents (R92) second step TST had results read and failed to ensure all the employees had been educated for the facility TB infection control plan. This had the potential to affect all 56 residents in the facility, staff and visitors. Findings include:	21426	1. Corrective Action: A. St. Mark�s Living will review most recent TB prevention and control Policy and Procedure issued by the CDC B. St. Mark�s Living TB policy will cover all paid and unpaid employees, contractors, students, residents and volunteers C. TB policy is in place and written compliance is maintained by St. Mark�s Living 2. Corrective Action as it applies to other Residents:	

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21426	Continued From page 21 Employee TB symptom screening and TST administration: E2 had a hire date of 2/5/16. The facility provided a TB screen dated 5/12/15 and first step TST dated 5/12/15 and second step dated 5/26/15. The facility failed to complete a TB symptom screening and first and second step TST upon hire as required. E3 had a hire date of 2/17/16. The facility provided a TB screen dated 3/3/15 and first step TST dated 3/3/15 and second step dated 3/1615. The facility failed to complete a TB symptom screening and first and second step TST upon hire as required. When interviewed on 11/17/16, at 12:06 p.m., registered nurse (RN)-C verified the above. TST Times of Administration and Read Results: E1 had a first step TST on 4/7/16, at 2:29 p.m. The TST was read on 4/10/16, but failed to include the time read. The second TST was given on 4/20/16, at 4:00 p.m. and read on 4/22/16, but failed to include the time read. E4 had a first step TST on 2/29/16, at 12:45 p.m., and read on 3/2/16, at 1:00 p.m. The second TST was given on 3/14/16 and read on 3/17/16, but failed to include the time of administration and the time read. E5 had a first step TST on 1/5/16 and read on 1/7/16, but failed to include the time of administration and the time read. The second TST was given on 1/20/16 and read on 1/22/16, but failed to include the time of administration and the time read.	21426	A. Nursing staff will be educated on the most recent distribution by the CDC for TB Prevention and Control Policy at POC meeting December 20th, 2016 B. St. Mark□s Living will have in place the most Recent TB policy C. St. Mark□s Living will keep written documentation of all TB□s per policy 2. Date of Completion: December 27th, 2016 4. Reoccurrence will be prevented by: A. Monthly audits will be performed and results discussed at QAPI B. Nursing staff will be educated on most recent policy by CDC for TB prevention and Procedure Policy at POC meeting December 20th, 2016. 5. Correction will be monitored by: A. DON or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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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.

Resident TST:
R92 was admitted on 8/4/16. R92's had a baseline TB screen and a first step TST. R92's record indicated a second step TST was given on 11/16/16, however the record failed to include the results of the second TST.

On 11/17/16, at 12:06 p.m., RN-C verified the above.

Staff Education:
On 11/17/16, at 12:06 p.m., RN-C confirmed the facility had not completed TB education with employees regarding the facility TB infection control plan. RN-C confirmed the TB education provided on the computer system failed to include the facility TB infection control plan.

The facility policy Tuberculosis (TB) Prevention and Control, dated 2/16, indicated in accordance with state and federal law health care facilities must ensure that employees, prior to employment and volunteers prior to volunteering show freedom from active TB. Employees and volunteers will have initial and periodic testing if necessary for TB. 3. An education program will be in place for employees/volunteers. This will consist of ongoing surveillance and implementation of policies in the event of a suspected or active case of TB at which time guidance and support are provided for the

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21426	Continued From page 23 employs/volunteer. Baseline screening at the time of hire is required for all health care workers in Minnesota. Baseline TB screening consists of two components (1) assessing for current symptoms of active TB disease and (2) testing for the presence of infection by administering a two-step TST or single TB blood test. All residents will receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. Baseline screening consists of three components (3) testing for the presence of infection by administering wither a two-step TST or a single blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate all employees regarding TB education and the facility infection control plan. The director of nursing could monitor compliance for screening and TST for employees and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		