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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LKMW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **11/20/2017** (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

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 :
Gary Nederhoff, Unit Supervisor 12/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 12/15/2017 (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) **00**

VOLUNTARY
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245369

December 15, 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 November 15, 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

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: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2017

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

RE: Project Number S5369028

Dear Mr. Finger:

On October 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 15, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2017, effective November 15, 2017 and therefore remedies outlined in our letter to you dated October 23, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LKMW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00394

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(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 **10/06/2017** (L34)

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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) :

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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 :
Stephanie Powers, HFE NE II 11/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 12/11/2017 (L20)

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

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

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25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
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02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
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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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2017

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

RE: Project Number S5369028

Dear Mr. Finger:

On October 6, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 15, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 6, 2018 (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 April 6, 2018 (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
Health Care Fire Inspections
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

cc: Licensing and Certification File

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 _____	10/06/2017

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 On October 2, 3, 4, 5, & 6, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (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 (that is, a deterioration in health, mental, or psychosocial	F 157		11/15/17

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

Electronically Signed | 10/27/2017

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 _____	10/06/2017

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 157	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified for a change in a resident weights for 1 of 1 resident (R21) reviewed for notification of change.	F 157	1. Corrective Action: A. Resident R 21, Clarified weight change orders. Staff educated on Change of Acute condition Policy and steps have been taken to inform physician, family and	

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 _____	10/06/2017

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 157	Continued From page 2 Findings include: R21's diagnoses included diastolic (congestive) heart failure (CHF) and lymphedema obtained from the facility admission record. During review of the Physician Orders, dated 9/1/17 it was revealed R21 had the following orders: -"Daily weight. In the morning Call Dr [medical doctor] is [if] pt [patient] increased more that [than] 2lbs in 3 days (reference Lasix order) -Lasix Tablet 40 MG (milligrams)(water pill-diuretic) Give 40 mg by mouth two times a day related to unspecified diastolic (congestive) heart failure. Call DR. [medical doctor] If weight increased more than 2 lbs in 3 days. Call for Lasix adjustment if Pt [patient] does not start to lose weight or is [if] weight loss is greater than 3lbs in one day (reference daily weight) -Metoprolol Succinate ER (anti-hypertensive) Tablet Extended Release 24 hours 25 MG to give 0.5 tablet by mouth one time a day related to essential hypertension. During review of the weights for September 2017, weights had been obtained as follows: -9/16/2017: 251 pounds (#) -9/15/2017: 252 # (3 # weight gain from 9/13/17) -9/14/2017 251 # -9/13/2017: 249 # -9/12/2017: 249 # -9/11/2017: 250 # -9/10/2017: 250 # -9/9/2017: 250 # -9/8/2017: 250 # -9/7/2017: 250 # -9/6/2017: 250 #	F 157	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 acute changes per policy C. Nursing staff educated on steps needed to inform those necessary individuals D. EMARS rewritten for all residents to make easier to read and alert nursing staff of a change in weights. 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on Acute Changes Policy at POC meeting, November 1st, 2017 B. Audits will be completed monthly and results discussed at weekly Risk Management meetings 5. Correction will be monitored by: A. DON or Executive Director B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed.	

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	245369	A. BUILDING _____ B. WING _____	10/06/2017

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F 157	Continued From page 3 -9/5/2017: 253 # (3 # weight gain since 9/2/17) -9/4/2017: 253 # -9/3/2017: 253 # -9/2/2017: 249 # -9/1/2017: 251 # R21's medical record lack documentation of the medical doctor and/or nurse practitioner being notified of the three pound weight gains on 9/5/17, and 9/15/17, as directed by the physician order. On 10/05/17, at 7:48 a.m. licensed practical nurse (LPN)-A verified the 9/5/17 and 9/15/17, weight gains, reviewed the interdisciplinary notes and verified the doctor had not been notified of the three pound gain in one day. LPN-A stated she would expect the doctor to have been notified per physician orders. On 10/05/17, at 8:59 a.m. the director of nursing (DON) stated she would have expected the doctor to be notified regarding the weight gain as directed by the physician order for R21. A policy was requested for following physician's orders and was not provided.	F 157		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must--	F 167		11/15/17

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F 167	Continued From page 4 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the state survey inspection results were readily available to residents, families, and state officials. Also interview with 2 of 2 residents (R67 & R22) as well as family member of R22 this had the potential to affect all 53 residents, visitors and staff. Findings include: During the initial tour of the facility on 10/2/17, at 8:40 a.m., the Survey book was located on a desk to the right of the entrance to the long-term care unit. Desk area is dark, empty except survey binder which was not posted or clearly visible from the hallway or entrance. A white binder with pink label on the outside, labeled State survey results.	F 167	Corrective Action: A. Facility will post where the most recent survey results can be found B. Signs will be posted at all main entrances and throughout the building 2. Corrective Action as it applies to other Residents: A. St. Mark□s Living will post at all main entrances and throughout the building our most recent survey results can be found 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Proper posting of signs for most recent survey results throughout the building. B. Audits will be completed monthly and results discussed at weekly Risk	

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F 167	Continued From page 5 On 10/5/17, at 2:45 p.m. R67 was asked if they new where the state results were located and R67 said they did not know. At 3:23 a.m. R37 and visiting family member (FM)-A, were asked if they knew location of survey results book and they both said they were not. At 3:10 p.m. nursing assistant (NA)-G a pool nurse said they were not sure where the state survey book was located in the facility. At 3:10 p.m. NA-H said, "I don't know the answer but I can find out for you" in regards to the location of the current state survey results. During interview on 10/4/17, at 2:10 p.m. with Director of Nursing. DON said, "There is no sign; there has never been a sign." Also said, "They [residents/family] usually just ask." It has always been on the desk and pointed to the desk across from the boardroom, right inside the entrance to the nursing home. A facility policy on survey results accessibility was requested and no policy provided, on 10/5/17, 5:22 p.m. DON stated there is no policy. We go by the Minnesota regulations. On 10/6/17, at 12:17 p.m. resident council representative R22 was interviewed and answered, "I don't know" when asked if they were aware of where the state survey results were located.	F 167	Management meetings 5. Correction will be monitored by: A. Executive director or designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 241		11/15/17

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F 241	Continued From page 6 her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 1 of 1 resident (R6) who was served their meal while sitting in the doorway to their room and required assistance with eating. Findings Include: R6 was observed on 10/2/17, at 11:52 a.m. seated in her Broda chair in the doorway to her room. Her lunch was placed on a tray table positioned in front of her. R6 was served chicken chow mien and a piece of peach pie. Nursing assistant (NA)-A was observed standing to her right side in the doorway to her room and assisted her to eat her lunch from 11:52 a.m. until 12:10 p.m. R6 was observed to be completely dependent on staff with eating. R6 was observed 10/4/17 at 9:01 a.m. seated in the doorway to her room in her Broda chair, tray table positioned in front of her with her breakfast tray. R6 had been provided a piece of toast cut into two slices with jelly and two beverages. R6 was observed to not be offered any assistance with eating her breakfast until 9:29 a.m. when registered nurse (RN)-A approached R6 and asked her if she was hungry and pushed R6 and the tray table into her room to assist her with eating her breakfast. RN-A was observed at 9:34 a.m. to be standing by R6 left side while she assisted her to drink her orange juice, water and eat one bite of her toast. RN-A stated R6 ate one bite of toast and drank 180 cc of fluids.	F 241	Corrective Action: A. Resident R6, Staff educated on the dignity of the residents and Policy on quality of life-dignity reviewed B. Resident is now in Main dining room for all meals 2. Corrective Action as it applies to other Residents: A. Will review quality of Life □ dignity policy for all residents at POC meeting. B. all staff will be educated on resident□s dignity and quality of life at POC meeting. 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on quality of Life- dignity Policy at POC meeting, November 1st, 2017 B. Audits will be completed weekly 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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F 241	Continued From page 7 R6's care plan directed staff to have R6 eat in the main dining room. Remind resident to eat slowly and chew thoroughly. EATING- set up/supervision, continuous reminders to stay on task. All meals use red dishes, glasses and silverware on white placemat for increased contrast. Cue resident to location of food and dishes as needed. Adjust care as condition changes. On 10/5/17, at 9:13 a.m. the director of nursing (DON) stated it was a dignity concern to have residents eat while located in doorway to their rooms. The DON stated it was a dignity concern to stand by a resident and assist them to eat. The DON stated she expected staff to sit down by the resident and assist them to eat. Review of Assistance with Meals policy dated September 2013, included, "3. Residents Requiring Full Assistance ... b. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity for example: (1) Not standing over residents while assisting them with meals ..."	F 241		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 244		11/15/17

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F 244	Continued From page 8 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to respond to grievances filed for maintaining enough linens, towels and gowns for the residents, 1 of 1 family member (FM)-D was interviewed and there is a potential to most residents residing in the facility. Findings include: Interview with family member (FM)-D on 10/2/17, at 10:40 a.m. FM-D stated the concern with adequate laundry started end of August this year when the residents were running out of linens, towels and gowns. FM-D spoke to the facility administrator but no changes had been seen. FM-D stated the facility changed companies from where they used to get laundry done. The new sheets were coming off the beds; FM-D stated she ended up buying their own to better fit the mattress. FM-D stated the new linens do not look clean, and there is not enough towels delivered. The staff have to use the resident clothes protectors to dry the residents off after they shower/bathe and sometimes there is not even enough gowns to place on the residents at night. Review of the grievance/concerns reports did not identify the concerns addressed in the past six months. Social Services (SS) was asked regarding specific concerns regarding the linens. SS stated those concerns go right to the	F 244	Corrective Action: A. Facility will respond in a timely manner when grievances/concerns are brought forward to administration B. Linens has been addressed by administrator, plans are in place for an alternative company. C. Forms will be readily available outside Social Workers door for families to access D. Grievance forms have been updated with an area for resolution contact and an area has been set out by social services for visitors to fill out grievances. 2. Corrective Action as it applies to other Residents: A. When a complaint/concern comes forward from a resident or family St. Mark□s a grievance form will be filled out with those individuals B. Concerns will be given to department heads who will then follow up with resident/family 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on Grievance Policy at POC meeting, November 1st, 2017 B. Audits will be completed monthly and results discussed at weekly Risk	

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F 244	Continued From page 9 administrator and the environmental services (ES). Interviews on 10/4/17, at 11:11 a.m. with nursing assistants (NA)-B and NA-C were asked if they ever run out of linens. NA-B stated two-three times a week and NA-B stated, "Never used to until they switched laundry services." NA-B and NA-C added they run out of hand towels, wash cloth, towels, and gowns. Surveyor asked what they use in place of those items. NA-B stated they improvise, and use bibs (clothing protectors) to dry the residents. Surveyor asked when the last time the shortage of linens had occurred, NA-B stated, Oh, well it happened this weekend, I had to use three washcloths, two to wash the resident and the other one to dry them, and sometimes the gowns are gone too, so we sometimes have to use shower gowns." Surveyor was taken to a clean utility room where NA-B showed a large denim blue colored sheet like a gown, NA-B then stated they would normally use them on the resident when transporting them in halls to and from bathing. Interview on 10/4/17, at 12:35 p.m. regarding availability of clean linens. NA-D also identified linen shortage and using other linens to wash/dry residents. NA-D added after the weekend it is the worst and we use whatever we can find. NA-D stated the administrator, the Director of Nursing and environmental services have been told. NA-D also said some families are buying their own linen for their loved ones. NA-D stated family tell staff they will bring more if they just call. On 10/4/17, at 3:33 p.m. administrator, ES and SS requested to speak to surveyor. Administrator stated they were aware of the situation and the	F 244	Management meetings C. Resident Council reviews will be a method to analyze grievances from the residents. 5. Correction will be monitored by: A. Executive director or Designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed.	

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F 244	Continued From page 10 old company was fired and had hired a new company due to cost issues and the new company had been in place for 60 days. Administrator stated the accrual form for grievances and concerns the surveyor had requesting had not been filled out because of so many complaints, administrator added he would be filling them out one after another. The new company they hired was identified with concerns immediately into the new contract. Surveyor asked how they are working around the concerns while continuously working with the company to fix their lack of supplying the facility with the correct amount of linen. Administrator stated staff would call the company when they run out of linen and they will attempt to deliver in half hour, but even then, they sometimes do not bring in the correct items or not enough again. Administrator was asked regarding the accommodation in place to supply the resident with the correct amount of linens, towels and gowns. Policy review titled Grievance Policy dated 7/1/17 reads; SS or designee will complete an investigation within 5 business days of receiving the complaint. SS or designee will advise family or resident of results within 5 business days.	F 244		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 247		11/15/17

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F 247	Continued From page 11 by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R22) reviewed for admission, transfer and discharge practices was notified timely of a room change. Findings include: R22's quarterly Minimum Data Set (MDS), dated 7/5/17, identified resident had moderate cognitive impairment. During interview on 10/3/17, at 1:11 p.m., R22 stated no one told me about moving to a different room. R22 said, "They just walked in and moved me out, nobody told me a damn thing!" R22 further stated, "I am not really satisfied with this room [new room], but what good does it do to bellyache about it? When I was in my other room people came and visited with me, now no one visits me anymore." On 10/3/17, at 7:14 p.m., R22 observed sitting in her wheelchair halfway pushed into the hallway from her room. R22 stated, "They moved me from that room down there, [resident is pointing down the hall], to this room here after my roommate died, because they had to replace the wall paper." R22 further stated no one said a word to her about the room change. R22 again said, "They just started moving my stuff. Now I don't have anyone to talk to anymore because they moved me way down at the end of the hall, I liked the other room better." On 10/4/17, at 11:06 a.m., during a phone interview with R22's guardian (G)-B stated she was not happy with R22's room change because R22 feels all alone now. Also stated she found out about the room change from R22 after she was already moved. G-B further stated, "I personally think they just moved R22 without telling her." During interview on 10/4/17, at 12:37 p.m.,	F 247	Corrective Action: A. Resident R22, Social worker educated on Transfer and Room to Room policy B. Transfer and Discharge Policy is in place 2. Corrective Action as it applies to other Residents: A. When a resident needs to be transferred to another room. Proper steps will be taken to ensure the Transfer and Room to room Policy is followed in a timely manner B. Social worker will keep a copy of all documents that are signed in a timely manner to ensure policy was followed 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Records will indicate tracking of all signed transfers for room to room B. Audits will be completed monthly and results discussed at weekly Risk Management meetings 5. Correction will be monitored by: A. Executive Director or Designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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F 247	Continued From page 12 Licensed Social Worker (LSW)-A stated she had identified R22 as one resident that did not like their room and that she could tell because "her tone of voice was not right." At 3:03 p.m. LSW-A verified R22 was transferred to new room on 9/22/17 and the transfer form was not signed by R22 until 9/26/17 four days after the room change. During interview on 10/4/17, at 3:07 p.m., Director of Nursing (DON) stated their facility policy and expectation for notification of a room change should be at least 24 hours in advance, the resident needs to agree to it and then it should be documented in the residents chart. Policy titled, Transfer, room to room, revised December 2016, indicates that unless medically necessary or for the safety and well-being of the resident (s), a resident will be provided with an advanced notice of the room transfer. Such notice will include the reason (s) why the move is recommended.	F 247		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow current pressure ulcer care plan interventions for 1 of 1 resident (R18) who had a pressure ulcer; failed to follow	F 282	Corrective Action: A. Resident R 18, R 50, and R 6. Staff educated in regards to the importance of following Care Plan	11/15/17

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F 282	Continued From page 13 care plan regarding transfering assistance for 1 of 1 resident (R50); faile to provide eating assistance per care plan assessement for 1 of 1 resident (R6) reviewed for activities of daily living was provided assistance with eating in accordance with the care plan; and failed to provide nursing rehabilitation services as care planned for 4 of 4 residents (R53, R28, R59, and R14) who were reviewed for range of motion services. Findings includes: R18 had been observed on 10/5/17 starting at 7:30 a.m. to 8:00 a.m. as R18 lying in bed slightly to the right side, facing window, floor matt on floor on left side of bed, pillow propped up against back. R18 quiet, eyes closed. At 8:00 a.m. R18res remains in the same position. Registered nurse (RN)-A and nursing assistant (NA) observed R18 in room but did not enter. From 8:00 a.m. to 9:09 a.m. R18 remained in same positoin as at 7:30 a.m. At 9:11 a.m. staff entered room and emptied trash, no cares given to R18 at this time. From 9:12 a.m to 9:51 a.m. no cares were given to R18 until licensed practical nurse (LPN)-B entered room, stating Hi, to R18. LPN-B then said I have pain medication for you. No change in positioning done at this visit. At 9:56 a.m. NA-I entered room to complete a.m. cares and reposition R18 at 10:15 a.m. Observation of right side while R18 had been turned showed a reddened area or discoloration noted on left side. NA-I confirmed that she had not been in room yet this shift to reposition resident. At 10:01 a.m. LPN-B return to room and said that NA-I had not been in R18's room since she started this a.m. LPN-B was asked when R18 had last been repositioned, LPN-B let room the	F 282	B. Care planning policy is in place C. Nursing staff educated on Pressure ulcer policy and Quality of Life- dignity Policy 2. Corrective Action as it applies to other Residents: A. Nursing staff will be educated on Care Planning during POC meeting B. Nursing staff will be educated on monitoring for skin changes per St. Mark□s Skin Assessment Policy at POC meeting 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on care planning and skin changes at POC meeting, November 1st, 2017 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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returned shortly after and said that R18 had been last repositioned according to documentation at 5:32 a.m. which was four hours and 43 minutes interval of not beeing repositioned.

On 10/5/17, at 10:28 a.m.NA-F who also cared for R18 was asked when R18 had last been repositioned and NA-F said, "I have not repositioned R18 this morning." At 10:29 a.m. NA-D who also provided cares for R18 said that she had not repositioned R18 also said she had only checked on her but had not repostioned her this a.m.

10/5/17, 3:42 p.m. RN-A stated, "I would expect that they [NAs] follow the care plan" RN-A stated that she can verify turning and repositioning.

10/5/17, at 4:55 p.m. during an interview with the director of nursing (DON0 it was learned that repositioning should occur a minimum of every two hours and as needed or per resident request. If pressure sore present it would depend on stage of ulcer. We would get wound consultant involved, evaluation, tissue tolerates, make the appropriate recommendation. I trust nurse mangers and their assessments. DON said, "I would expect them to follow plan of care."

R18 had been readmitted after hospitalization on 4/6/17 according to discharge notes, is a long term resident, has diagnosis for major depressive disorder, diabetes, pressure ulcer to sacrum, chronic kidney disease stage 3. Hypertension, Unspecified psychosis not due to substance or known physiological condition, dementia with behavior disturbances, general anxiety disorder, essential tremors.

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R18's Care Plan indicateed they had a current open area to sacrum, and required assist of 1-2 staff for bed mobility every 2 hours and as needed. Every 1 hours when in chair, added 7/3/17 to be laid down after meals.

Received policy for support surface guidelines, date revised February 2014. The purpose of the procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk for skin breakdown. Under interventions/care strategies states: for residents that recline and depend on staff for repositioning, change positions at least every 2 hours.

R50's quarterly Minimal Data Set dated 8/17/17, reads cognition score is a 13 indicating R50 cognition is intact. Activities of daily living identifies R50 required extensive assistance with bed mobility, transfers, toilet use with two persons.

R50's Care plan reviewed, reads, assist of 2 AND GAIT BELT (capital letters written in care plan) with all transfers and toilet use. With a focus identified for fall and safety risk, DO not leave resident unattended on the toilet. R50 has multiple aches and pains including back and vertebral process and especially right hand pain. The goals identified is R50will not have an interruption in normal activities due to pain and will verbalize adequate relief of pain or ability to cope with incompletely relieved pain. Interventions is R50's pain is alleviated/relieved by medication and rest, anticipate R50's need for pain relief and respond immediately to any complaint of pain, monitor/record/report to nurse resident complaints of pain or requests for pain

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treatment, and report to nurse an changed in usual activity attendance patterns or refusal to attend activities related to signs/symptoms or complaints of pain or discomfort.

Observation on 10/5/17, at 7:56 a.m. nursing assistant (NA)-E in room with R50. During this observation a faded bruise on upper chest, asked R50 how received the bruise , R50 not sure, but stated it hurts. NA-E assisted R50 with one person and use of transfer gait belt and four wheel walker from edge of bed to wheelchair, when attempted to sit in wheelchair. NA-E assisted R50 to the bathroom and transfered her independently unto the toilet.At 7:59 a.m. NA-E left room while R50 was seated on toilet. A few minutes later NA-E returned to bathrrom and said she had informed the nurse of R50's pain with movement. At 8:05 a.m. licensed practical nurse (LPN)-B came in with Tylenol to give to resident. Surveyor asked LPN-B how many staff are required to safely transfer R50. LPN-B, stated, "I thought it was two." LPN-B left the room and returned and said it was two staff to assist R50 with tranfers.

Interview on 10/5/17, at 8:56 a.m. registered nurse (RN)-B stated R50 is assessed to need two staff assist with all transfers, adding this occured after R50 had a fall a while ago.

Interview on 10/5/17, at 2:48 p.m. Director of Nursing (DON) stated her expectation is to follow the care plan.

Facility policies were requested for care planning, none were received.
FAILED TO FOLLOW THE CARE PLAN FOR EATING ASSISTANCE

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R6's face sheet, dated 10/4/17, identified a diagnosis of dementia and macular degeneration.

R6's quarterly Minimum Data Set (MDS), dated 8/16/17 indicated R6 had severely impaired decision-making skills for daily livening. The MDS also identified R42 required supervision oversight, cueing and encouragement of one staff for eating.

R6's care area assessment (CAA) for activities of daily living (ADLs) printed 3/17/17, indicated R6 required supervision with eating. Resident is enrolled in Hospice and goals for care are comfort and dignity. Action: Will proceed to care plan. Staff will continue to assist resident as needed. Staff will adjust care as needed as condition declines to maintain resident's comfort and dignity.

R6's care plan directed staff to have R6 eat in the main dining room. Remind resident to eat slowly and chew thoroughly. EATING- set up/supervision, continuous reminders to stay on task. All meals use red dishes, glasses and silverware on white placemat for increased contrast. Cue resident to location of food and dishes PRN. Adjust care as condition changes.

R6 was observed on 10/2/17, at 11:52 a.m. to seated in her broad wheelchair in the doorway to her room. Her lunch was placed on a tray table positioned in front of her. R6 was served chicken chow mein and a piece of peach pie. Nursing assistant (NA)-A was observed standing to her right side in the doorway to her room and assisted her to eat her lunch from 11:52 a.m. until 12:10 p.m. R6 was observed to be

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completely dependent on staff with eating.

R6 was observed 10/4/17 at 9:01 a.m. to be seated in the doorway to her room in her Broda chair, tray table positioned in front of her with her breakfast tray. R6 had been provided a piece of toast cut into two slices with jelly and two beverages. R6 was observed to not be offered any assistance with eating her breakfast until 9:29 a.m. when registered nurse (RN)-A approached R6 and asked her if she was hungry and pushed R6 and the tray table into her room to assist her with eating her breakfast. RN-A was observed at 9:34 a.m. to be standing by R6 left side while she assisted her drink her orange juice, water and one bite of her toast. RN-A stated R6 ate one bite of toast and drank 180 cc of fluids. R6 was observed to be completely dependent on staff with eating. During this continuous observation from 9:01 a.m. to 9:29 a.m. nine nursing staff members were observed to walk by resident and not offer any encouragement, cueing or assistance to R6 with eating.

On 10/5/17, at 9:26 a.m. the director of nursing (DON) stated she expected the staff to have the curtesy to take the time to sit with R6 and assist her to eat her meals. The DON stated R6 was a total assist with eating at this time as she had declined over the past six months. The DON expected staff to stay with R6 when she was eating to provide continuous reminders to stay on task with eating or assist her with eating if R6 was observed to not eat on her own. The DON stated depending on her level of function for the day, she expected staff to adjust the level of assistance provided. The DON stated R6's care plan instructed staff to adjust cares with changes.

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The DON verified staff did not follow the care plan to provide continuous encouragement to stay on task or to adjust R6's cares with changes. The DON stated she expected the staff to follow the care plan.

A policy related to following the care plan was requested, none was provided.
R53 had been interviewed on 10/5/17, at 2:43 p.m., R53 stated, "I used to do the Nu step all the time." I have not been able to walk far for the past 3 weeks, probably from lack of doing it, the aides don't have time. I am not sure if they are doing the restorative program here with anyone anymore, I don't see anyone doing it here like I used to. "I feel like they are short changing everyone by not having time to do the restorative program with people. I think it is a shame!" "They are just too short staffed here!"

R53 was admitted to the facility on 5/31/17, with diagnosis of Parkinson's disease, according to the resident face sheet.

Facility Care Plan dated 8/31/17, identified R53's restorative programs goals are: maintain ability to ambulate to therapy gym daily. Ambulate with wheeled walker with stand by assist, Nu step level 5 for 10-15 minutes per day, and complete standing exercises.

Significant change minimum dtat set (MDS) dated 7/27/17, indicated R53 to have intact cognition and requires one person extensive assist with ambulation.

R53 had a Restorative Care Program dated 7/10/17, which indicated R53 was discharged from physical therapy on this date, and R53's

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recommendations were to follow therapy's recommended exercises to maintain ability to walk and complete activities of daily living with limited assist.

Record review of Activity Exercise Program revealed:

July, 2017: 0 of 21 days of walking attempted. 2 of 21 days of exercises attempted.
August, 2017: 2 of 31 days of walking attempted. 8 of 31 days of exercises attempted.
September, 2017: 0 of 30 days of walking attempted. 1 of 30 days of exercises attempted.
October, 2017: 0 of 5 days of walking attempted. 1 of 5 days of exercises attempted.

During interview on 10/5/17, at 2:53 p.m., R28 stated no one ever comes in to walk me to the nurse's station. R28's daughter and son that were in the R28's room stated they had never witnessed anyone walking with R28 as well.

R28 was admitted to the facility on 7/21/15, with a diagnosis of major depressive disorder and dementia, according to the resident face sheet.

Facility Care Plan dated 9/12/17, identified R28's restorative programs goals are: ambulation program to maintain mobility. Will ambulate with staff daily.

Quarterly MDS dated 8/30/17, indicated R28 to have severe cognitive impairment and requires one person limited assist with ambulation.

Record review of Activity Exercise Program revealed:

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July, 2017: 2 of 31 days of daily walking attempted. 7 of 31 days of active range of motion (AROM) attempted.
August, 2017: 0 of 31 days of daily walking attempted. 7 of 31 days of AROM attempted.
September, 2017: 19 of 30 days of daily walking attempted. 2 of 30 days of AROM attempted.
October, 2017: 3 of 5 days of daily walking attempted. 0 of 5 days of AROM attempted.

During interview on 10/5/17, at 3:14 p.m., when asked if R59 would be able to walk to the therapy room R59 said, "It would probably be best if I did." I don't think I would be able to, I get too short of breath, the last time I did that was probably 2 months ago.

R59 was admitted to the facility on 7/13/17, with diagnosis of Chronic Obstructive Pulmonary Disease (COPD) -progressive lung disease and pneumonia, according to the resident face sheet.

Facility Care Plan dated 8/31/17, identified R59's restorative programs goals are: maintain ability to transfer independently from wheel chair level through next date. Walk to and from therapy room with wheelchair to follow for 50-100 feet, standing exercises, Nu step 10-15 minutes per day, and blow cotton balls across the table with a straw, with the straw suck it into the straw and put in a cup, 5 sets.

Fourteen day MDS dated 8/17/17, indicated R59 to have intatc cognition and requires one person extensive assist with ambulation.

Restorative Care Program dated 8/26/17, indicated resident was discharged from occupational therapy on this date, and discharged

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from physical therapy on 8/28/17, and R59's recommendations were to follow therapy's recommended exercises to maintain current level of function.

Record review of Activity Exercise Program revealed:

August, 2017: 0 of 2 days walking attempted. 0 of 2 days of above exercises completed.
September, 2017: 19 of 30 days walking attempted. 7 of 30 days of above exercises attempted.
October, 2017: 2 of 5 days of walking attempted. 1 of 5 days of above exercises attempted.

R14 was admitted to the facility on 11/7/13, with diagnosis of Hemiplegia (paralysis on one side of the body) following a Cerebrovascular accident (when blood flow to your brain stops and brain cells start to die), affecting left dominant side, according to Resident Face Sheet.

Facility Care Plan dated 8/11/17, identified R14's restorative program goal is to maintain strength and range of motion (ROM) to maintain ability to participate in EZ standtransfers (device used to transfer a person from one location to another), with no complaints of shoulder pain. Also identified maintain R14's participation in upper extremity dressing by raising up non affected side without complaining of pain.

Annual MDS dated 8/3/17, indicated R14 to have severe cognitive impairment and requires extensive assist of one person for transfers.

Restorative Care Program dated 4/14/16, indicated resident was discharged from therapy

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on this date R14's recommendations were to follow therapy's recommended exercises to maintain strength and range of motion.

Record review of Activity Exercise Program revealed:

July, 2017: 2 of 13 days of exercises attempted. 5 of 31 days of passive range of motion (PROM) exercises attempted.
August, 2017: 3 of 14 days of exercises attempted. 9 of 31 PROM days of exercises attempted.
September, 2017: 2 of 13 days of exercises attempted. 3 of 30 days of PROM exercises attempted.
October, 2017: 0 of 5 days of exercises attempted. 1 of 5 days of PROM exercises attempted.

On 10/5/17, at 12:29 p.m. the director of nursing (DON) stated when the restorative aides are pulled to cover the floor, there is not a staff member covering restorative services. The DON stated staffing is tough all over and we have even asked if we should have the aides doing range of motion services. The DON stated part of the reason the restorative services were not being done was because of staffing. The facility had a restorative aide retire and a restorative aide went on maternity leave and did not return to work.

On 10/5/17, at 1:05 p.m. registered nurse (RN)-B stated we do not have the staffing to provide the restorative program. The restorative aides that are scheduled to provide restorative nursing services are being pulled to work on the floor. RN-B stated used to have consistent staff in place and restorative meetings regularly. The last

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restorative meeting we had was on 5/3/17. RN-B stated the main restorative aide retired, one restorative aide was on maternity leave and did not return to work. RN-B stated the facility currently had two restorative aides. RN-B residents were supposed to be having programs five days a week. We are lucky if they provide the service two days a week. RN-B stated the facility was trying to hire more staff. RN-B stated the facility planned to have a meeting as soon as possible to evaluate the residents on the program to see if the current program was still appropriate, if it needed to be updated and to see if therapy needed to get involved again. RN-B stated the facility was looking at having a meeting to determine how the facility will proceed with the restorative program because if the restorative aides are being pulled to cover the floor the program was not working.

On 10/5/17, at 1:33 p.m. the DON stated she spoke with registered nurse (RN)-B and the restorative program was, "pretty much nonexistent at this time."

On 10/5/17, at 2:12 p.m. registered nurse (RN)-A stated the restorative aides are being assigned to work on the floor right now. RN-A stated when the restorative aides are pulled to the floor, restorative services are not being provided to the residents. RN-A stated there were twenty-four long-term care residents that received restorative services. RN-A stated if there was a call in they (the restorative aides) would get pulled to the floor. There is no other way to fix it.

Interview with DON on 10/6/17, at 10:57 a.m., verifies there has been staffing issues in the last 6 months where the restorative nursing staff get

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F 282	Continued From page 25 pulled to the floor when they are short of staff. Further verifies that the facility is not following their restorative nursing policy. During interview on 10/6/17, at 11:04 a.m., with director of restorative therapy (DOR)-C verifies if restorative therapy is not done it could cause a decline. Specifically with R53 it could cause a decline in her ability to transfer herself safely. With R59, his breathing could be compromised if the activities are not completed and he could get pneumonia again. "We wanted to keep those lungs nice and clear." With R14 could lose strength to complete transfers and could get contractures in his extremities from not getting the stretches done. With R28 if therapy is not done on a daily basis it could be a decline in her ability to, "transfer safely," and decline in her activities of daily living. In regards to restorative therapy and the staffing, "I noticed in the last 6 months it's been rough." On 10/6/17, at 11:56 a.m., DON verified that the care plan is not being followed for their facility restorative nursing program. A policy was requested for following the care plan and one was not received.	F 282		
F 311 SS=E	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by:	F 311		11/15/17

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F 311	Continued From page 26 Based on interview and record review, the facility failed to ensure that 4 of 4 residents, (R53, R28, R59, and R14) reviewed for activities of daily living, were provided restorative nursing care as ordered. Findings include: R53 had been interviewed on 10/5/17, at 2:43 p.m., and stated, "I used to do the Nu step all the time." I have not been able to walk far for the past 3 weeks, probably from lack of doing it, the aides [nursing assistants] don't have time. I am not sure if they are doing the restorative program here with anyone anymore, I don't see anyone doing it here like I used to. "I feel like they are short changing everyone by not having time to do the restorative program with people. I think it is a shame." "They are just too short staffed here!" R53 was admitted to the facility on 5/31/17, with diagnosis of Parkinson's disease, according to the resident face sheet. R53's Care Plan dated 8/31/17, identified R53's restorative programs goals are: maintain ability to ambulate to therapy gym daily. Ambulate with wheeled walker with stand by assist, Nu step level 5 for 10-15 minutes per day, and complete standing exercises. Significant change Minimum Data Set (MDS) dated 7/27/17, indicated R53 to have intact cognition and requires one person extensive assist with ambulation. Restorative Care Program notes dated 7/10/17, indicated R53 was discharged from physical therapy on this date, and recommendations were	F 311	1. Corrective Action: A. Resident R53, R28, R59 and R14 Facility will respond by moving Restorative duties (ROM and walks) to the floor staff B. Floor staff will be educated by therapy on proper techniques for ROM C. Therapy will test out each floor staff to ensure they are using proper techniques. D. Care Plans will be updated to reflect the changes 2. Corrective Action as it applies to other Residents: A. Staff will be educated on proper ROM techniques from therapy department B. Quarterly review of ROM techniques will be held for staff by therapy to ensure proper techniques C. Walks will be monitored by charge nurses to ensure they are completed as scheduled. 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Audits will be monitored and reviewed for resident□s ability to maintain ADL□s B. Audits will be completed weekly X4 and monthly X3. 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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to follow therapy's recommended exercises to maintain ability to walk and complete activities of daily living with limited assist.

Record review of Activity Exercise Program revealed:

July, 2017: 0 of 21 days of walking attempted. 2 of 21 days of exercises attempted.
August, 2017: 2 of 31 days of walking attempted. 8 of 31 days of exercises attempted.
September, 2017: 0 of 30 days of walking attempted. 1 of 30 days of exercises attempted.
October, 2017: 0 of 5 days of walking attempted. 1 of 5 days of exercises attempted.

R28 had been interviewed on 10/5/17, at 2:53 p.m., R28 stated no one ever comes in to walk me to the nurse's station. R28's family members (FM)-E & F were in the R28's room and they both stated they had never witnessed anyone walking with R28 as well.

R28 was admitted to the facility on 7/21/15, with a diagnosis of major depressive disorder and dementia, according to the resident face sheet.

R28's Care Plan dated 9/12/17, identified R28's restorative programs goals are: ambulation program to maintain mobility. Will ambulate with staff daily.

Quarterly MDS dated 8/30/17, indicated R28 to have severe cognitive impairment and requires one person limited assist with ambulation.

Record review of Activity Exercise Program revealed:

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July, 2017: 2 of 31 days of daily walking attempted.
August, 2017: 0 of 31 days of daily walking attempted.
September, 2017: 19 of 30 days of daily walking attempted.
October, 2017: 3 of 5 days of daily walking attempted.

R59 had been observed/interviewed on 10/5/17, at 3:14 p.m., when asked if R59 would be able to walk to the therapy room R59 said, "It would probably be best if I did." I don't think I would be able to, I get too short of breath, the last time I did that was probably 2 months ago.

R59 was admitted to the facility on 7/13/17, with diagnosis of Chronic Obstructive Pulmonary Disease (COPD) -progressive lung disease and pneumonia, according to the resident face sheet.

R59's Care Plan dated 8/31/17, identified R59's restorative programs goals are: maintain ability to transfer independently from wheel chair level through next date. Walk to and from therapy room with wheelchair to follow for 50-100 feet, standing exercises, Nu step 10-15 minutes per day, and blow cotton balls across the table with a straw, with the straw suck it into the straw and put in a cup, 5 sets.

Fourteen day MDS dated 8/17/17, indicated R59 to have intact cognition and requires one person extensive assist with ambulation.

Restorative Care Program dated 8/26/17, indicated resident was discharged from occupational therapy on this date, and discharged from physical therapy on 8/28/17, and R59's

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recommendations were to follow therapy's recommended exercises to maintain current level of function.

Record review of Activity Exercise Program revealed:

August, 2017: 0 of 2 days walking attempted. 0 of 2 days of above exercises completed.
September, 2017: 19 of 30 days walking attempted. 7 of 30 days of above exercises attempted.
October, 2017: 2 of 5 days of walking attempted. 1 of 5 days of above exercises attempted.

R14 was admitted to the facility on 11/7/13, with diagnosis of Hemiplegia (paralysis on one side of the body) following a Cerebrovascular accident (when blood flow to your brain stops and brain cells start to die), affecting left dominant side, according to Resident Face Sheet.

R14's Care Plan dated 8/11/17, identified R14's restorative program goal is to maintain strength and range of motion (ROM) to maintain ability to participate in EZ stand transfers (device used to transfer a person from one location to another), with no complaints of shoulder pain. Also identified maintain R14's participation in upper extremity dressing by raising up non-affected side without complaining of pain.

Annual MDS dated 8/3/17, indicated R14 to have severe cognitive impairment and requires extensive assist of one person for transfers.

Restorative Care Program dated 4/14/16, indicated resident was discharged from therapy on this date R14's recommendations were to

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follow therapy's recommended exercises to maintain strength and range of motion.

Record review of Activity Exercise Program revealed:

July, 2017: 2 of 13 days of exercises attempted. 5 of 31 days of passive range of motion (PROM) exercises attempted.
August, 2017: 3 of 14 days of exercises attempted. 9 of 31 PROM days of exercises attempted.
September, 2017: 2 of 13 days of exercises attempted. 3 of 30 days of PROM exercises attempted.
October, 2017: 0 of 5 days of exercises attempted. 1 of 5 days of PROM exercises attempted.

On 10/5/17, at 12:29 p.m. the director of nursing (DON) stated when the restorative aides are pulled to cover the floor, there is not a staff member assigned to complete restorative services. The DON stated staffing is tough all over and we have even asked if we should have the aides doing range of motion services. The DON stated part of the reason the restorative services were not being done was because of staffing. The facility had a restorative aide retire and a restorative aide went on maternity leave and did not return to work.

On 10/5/17, at 1:05 p.m. registered nurse (RN)-B stated we do not have the staffing to provide the restorative program. The restorative aides that are scheduled to provide restorative nursing services are being pulled to work on the floor. RN-B stated used to have consistent staff in place and restorative meetings regularly. The last

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restorative meeting we had was on 5/3/17. RN-B stated the main restorative aide retired, one restorative aide was on maternity leave and did not return to work. RN-B stated the facility currently had two restorative aides. RN-B residents were supposed to be having programs five days a week. We are lucky if they provide the service two days a week. RN-B stated the facility was trying to hire more staff. RN-B stated the facility planned to have a meeting as soon as possible to evaluate the residents on the program to see if the current program was still appropriate, if it needed to be updated and to see if therapy needed to get involved again. RN-B stated the facility was looking at having a meeting to determine how the facility will proceed with the restorative program because if the restorative aides are being pulled to cover the floor.

On 10/5/17, at 1:33 p.m. the DON stated she spoke with registered nurse (RN)-B and the restorative program was, "pretty much nonexistent at this time."

Interview with DON on 10/6/17, at 10:57 a.m., verified there has been staffing issues in the last 6 months where the restorative nursing staff get pulled to the floor when they are short staffed. Further verifies that the facility is not following their restorative nursing policy.

During interview on 10/6/17, at 11:04 a.m., with director of restorative therapy (DOR)-C verifies if restorative therapy is not done it could cause a decline. Specifically with R53 it could cause a decline in her ability to transfer herself safely. With R59, his breathing could be compromised if the activities are not completed and he could get pneumonia again. "We wanted to keep those

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F 311	Continued From page 32 lungs nice and clear." With R14 could lose strength to complete transfers and could get contractures in his extremities from not getting the stretches done. With R28 if therapy is not done on a daily basis it could be a decline in her ability to, "transfer safely," and decline in her activities of daily living. In regards to restorative therapy and the staffing, "I noticed in the last 6 months it's been rough." However, there has not been any resident who has shown a decline. A policy, "Restorative Nursing Care," dated 2001, revised April, 2013, reveals rehabilitative nursing care is performed daily for those residents who require such service.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assisting with eating was provided for 1 of 1 resident (R6) reviewed who was assessed to need assistance to eat meals. Findings Include: R6's face sheet, dated 10/4/17 identified a diagnosis of dementia and macular degeneration. R6's quarterly Minimum Data Set (MDS), dated 8/16/17 indicated R6 had severely impaired decision-making skills for daily livening. The MDS also identified R6 required supervision oversight,	F 312	Corrective Action: A. Resident R6, Staff educated on importance of ADL assistance and following Care Plan B. Resident is now in Main dining room for all meals 2. Corrective Action as it applies to other Residents: A. Will review quality of Life □ dignity policy for all residents at POC meeting. B. All staff will be educated on resident□s dignity and quality of life at POC meeting. 3. Date of Completion: November	11/15/17

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F 312	Continued From page 33 cueing and encouragement of one staff for eating. R6's care area assessment (CAA) for activities of daily living (ADLs) printed 3/17/17, indicated R6 required supervision with eating. Resident is enrolled in Hospice and goals for care are comfort and dignity. Action: Will proceed to care plan. Staff will continue to assist resident as needed. Staff will adjust care as needed as condition declines to maintain resident's comfort and dignity. R6's care plan directed staff to have R6 eat in the main dining room. Remind resident to eat slowly and chew thoroughly. EATING- set up/supervision, continuous reminders to stay on task. All meals use red dishes, glasses and silverware on white placemat for increased contrast. Cue resident to location of food and dishes as needed. Adjust care as condition changes. R6 was observed on 10/2/17 at 11:52 a.m. seated in her Broda chair located in the doorway to her room. Her lunch was placed on a tray table positioned in front of her. R6 was served chicken chow mien and a piece of peach pie. Nursing assistant (NA)-A was observed standing to her right side in the doorway to her room and assisted her to eat her lunch from 11:52 a.m. until 12:10 p.m. R6 was observed to be completely dependent on staff with eating. R6 was observed 10/4/17 at 9:01 a.m. to be seated in the doorway to her room in her broda chair, tray table positioned in front of her with her breakfast tray. R6 had been provided a piece of toast cut into two slices with jelly and two	F 312	15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff education on quality of Life- dignity Policy at POC meeting, November 1st, 2017 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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F 312	Continued From page 34 beverages. R6 was observed to not be offered any assistance with eating her breakfast until 9:29 a.m. when registered nurse (RN)-A approached R6 and asked her if she was hungry and pushed R6 and the tray table into her room to assist her with eating her breakfast. RN-A was observed at 9:34 a.m. to be standing by R6 left side while she assisted her drink her orange juice, water and one bite of her toast. RN-A stated R6 ate one bite of toast and drank 180 cc of fluids. R6 was observed to be completely dependent on staff with eating. During this continuous observation from 9:01 a.m. to 9:29 a.m. nine nursing staff members were observed to walk by resident and not offer any encouragement, cueing or assistance to R6 with eating. On 10/5/17, at 9:26 a.m. the director of nursing (DON) stated she expected the staff to have the courtesy to take the time to sit with R6 and assist her to eat her meals. The DON stated R6 was a total assist with eating at this time as she had declined over the past six months. Review of Assistance with Meals policy dated September 2013, included, "3. Residents Requiring Full Assistance ... b. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity for example: (1) Not standing over residents while assisting them with meals ..."	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		11/15/17

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F 323	Continued From page 35 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow most current assessed need for staff assistance to prevent falls for 1 of 1 resident (R50) who had been assessed after a fall with injury to need two staff assist for all transfers. Findings include: R50's admission record read initial admission was 3-6-17, with diagnosis of heart attack, traumatic fracture, breast cancer, osteoporosis, with new diagnosis added 7/11/17, history of traumatic brain injury and history of falling and kidney failure.	F 323	. Corrective Action: A. Resident R 50, nursing staff educated on the importance of following Care Plan. B. Falls Risk Assessment Policy is in Place 2. Corrective Action as it applies to other Residents: A. Nursing staff will be educated on following care plan and Fall Risk Assessment Policy at POC meeting B. Safety and Supervision of Rights Policy is in place 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented	

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F 323	Continued From page 36 Review of the Quarterly Minimal Data Set dated 8/17/17, read cognition score is a 13 indicating R50 cognition is intact. Activities of daily living identifies R50 requires extensive assistance with bed mobility, transfers, toilet use with two persons and extensive assist with dressing and personal hygiene with one person. R50's care plan reads, assist of "2 AND GAIT BELT" with all transfers and toilet use. With a focus identified for fall and safety risk, "DO" not leave resident unattended on the toilet. Observation on 10/5/17, at 7:56 a.m. nursing assistant (NA)-E in room with R50. NA-E transferred R50 alone using a gait belt and four wheel walker from edge of bed to wheelchair, when R50 attempted to sit in wheelchair it started to move backwards. NA-E stated, "Her brakes do not work real well." After R50 was seated in the wheel chair she was taken to the bathroom and transferred to the toilet. After a minute NA-E left R50 on the toilet alone. Four minutes (8:01 a.m.) later NA-E returned to the bathroom and said she had talked to the nurse regarding R50 complaint of pain. At 8:05 a.m. licensed practical nurse (LPN)-B came in with Tylenol to give to resident. Surveyor asked NA-E in a private area how many person assist was required for R50. NA-E stated R50 was a one person assist as documented on care sheet. Several minutes later surveyor asked LPN-B what R50 was assessed to need when transferred. LPN-B, Stated, "I thought it was two." LPN-B then left the room leaving NA-E and surveyor in room with R50. Shortly after LPN-B left the room NA-E independently transferred R50 from the toilet to her wheelchair.	F 323	by: A. Nursing staff educated on polies at POC meeting, November 1st, 2017 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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F 323	Continued From page 37	F 323		

On 10/5/17 at 8:29 a.m. with NA-E regarding cares for R50. NA-E stated, "The last time down this wing R50 was one assist." NA-E added it is her responsibility to review the care sheet to know the updates regarding cares for R50. NA-E and surveyor reviewed the care sheet titled, Wing, 4/5 Group Sheet. NA-E stated that R50 was to have two staff assist to transfer. NA-E was asked regarding the loose brakes on the wheelchair stating, "It never use to be like that." Regarding the process and what will occur now, NA-E will be placing the request to have wheel chair brakes fixed, which is done on the computer, the request then goes to maintenance.

Interview on 10/5/17 at 8:52 a.m. with Registered Nurse (RN)-A stated the NAs get their updates regarding resident transfers from task list, their tablets, their computer and at times the nurse managers will go tell the staff the changes. There is also an assignment sheet on the floor that NAs have access with the most current care plan needs for the residents. On asking about R50s transfer assistance RN-A stated R50 is a two assist due to falls.

Interview on 10/5/17 at 8:56 a.m. RN-B who is assigned to R50's cares/services, stated R50 is an assist of two with all transfers, adding this information had been updated on care plan and available to NAs when giving cares. RN-B said R50 use to be a one person assist but changed to two staff assist after falling a while ago.

A falls assessment completed 8/17/17 titled Morse fall. R50 had a score of 65 which identified being at high risk for falls. The assessments as reads R50 does know her own limits.

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 _____	10/06/2017

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 323	Continued From page 38 R50's incident report included she had sustained a fall with injury on 9-3-17 after being assist with one staff and unexplained bruising to the chest. No falls have occurred after this incident. Interview on 10/5/17, at 2:48 p.m. the director of nursing (DON) had been asked concerning R50's fall and transfer status. DON stated her expectation is for the NAs to follow the current resident care plan regarding staff assistance for transferring. During a telephone interview on 10/5/17, at 3:04 p.m. with the maintenance director regarding R50's needing wheel chair brakes fixed. MD said they received the request from staff to fix R50's wheelchair brakes.	F 323		
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353		11/15/17

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 353	Continued From page 39 (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently provide nursing staff to meet each resident's assessed needs in a timely manner for 7 of 7 residents (R53, R28, R59, R14, R18, R50, R6) reviewed for having their needs met. This also could affect all 53 residents if staffing was not sufficient to care for their identified needs as well. Findings Include:	F 353	Corrective Action: A. Residents R53, R28, R59, R14, R18, R50 and R6. Facility will have sufficient nursing staff to provide appropriate services to the residents. B. Facility re arranged job duties with restorative to free up their workload to enable help on the floor 6 AM to 9 AM C. Facility is hiring unit attendants to help lessen the burden for the NARS.	

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F 353	Continued From page 40 ASSESSED RESIDENT NEEDS NOT BEING MET: See F311: The facility failed to ensure that 4 of 4 residents, (R53, R28, R59, and R14) reviewed for activities of daily living, were provided restorative nursing care as ordered for the past several months. See F312: The facility failed to ensure assisting with eating was provided for 1 of 1 resident (R6) reviewed who was observed to be dependent upon staff for assistance with eating. See F314: The facility failed to completed weekly wound documentation 1 of 1 resident (R18) who has current pressure ulcer to sacrum reviewed for pressure ulcers, resulting in harm by worsening of pressure ulcer from healing stage 3 to unstageable. See F323: The facility failed to transfer with the appropriate staff for resident (R50) reviewed for accidents, which had the potential for an incident when the wheel chair brakes were noticed to be malfunctioning during the one staff assist transfer when R50 was assessed to need two person assist and not left alone unattended in bathroom. RESIDENT CONCERN WITH LACK OF STAFFING: On 10/5/17 at 2:43 p.m., R53 stated, "I used to do the Nu step all the time." I have not been able to walk far for the past 3 weeks, probably from lack of doing it, the aides don't have time. I am not sure if they are doing the restorative program here with anyone anymore, I don't see anyone	F 353	D. Will continue to interview applicants as they come forth E. Will review with Scheduler the duties and expectation s to fill the shifts 2. Corrective Action as it applies to other Residents: A. Nursing staff will be educated on changes made at POC meeting. B. Scheduler will meet with Administrator daily to review schedule. C. Focus group will be held Oct. 31st, 2017 for staff to air their grievance to administration. 3. Date of Completion: November 15, 2017 4. Reoccurrence will be prevented by: A. Nursing staff will be educated on the changes made at the POC meeting, November 1st, 2017 B. Audits will be completed weekly X4 and Monthly 3 X3. Results discussed at weekly risk Management meetings C. Speaker will present to staff on teamwork and time management 5. Correction will be monitored by: A. Executive Director or Designee B. QAPI committee will review audits on a quarterly basis and will provide further direction if needed	

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doing it here like I used to. "I feel like they are short changing everyone by not having time to do the restorative program with people. I think it is a shame!" "They are just too short staffed here!"

STAFF CONCERNS WITH LACK OF STAFFING:

On 10/5/17, at 9:28 a.m., nursing assistant (NA)-I stated I am asked all the time to come in early, stay late, work overtime, "all the time." They up scheduled, (put a person on the schedule that was not scheduled to cover a shift), me today, it was supposed to be my day off. They can up schedule us two times a pay period. I do not feel we have sufficient staff to do our work most of the time. Some of the things that don't get done are: beds not being made, sometimes we don't even get our showers done. Its especially bad on wing three, people have lots of behaviors on that wing and need 1:1 assistance, they are crawling out of their beds. We are fully staffed now that you are here. We run out of towels because laundry only comes Mondays, Wednesdays, and Fridays. We have complained several times and management does nothing.

On 10/05/17, 9:37 a.m., licensed practical nurse (LPN)-C stated, I am asked to come in early, stay late and work overtime. "Honestly, I do not think we have enough staff to get our work done most of the time. They need more help!" One time we had to move all of the residents from the TCU (Trans Care Unit) for the whole weekend, to wings three and four because I was the only nurse in the whole building for all three wings. I think there are more errors when we are short staffed. It is the same for our nursing assistants (NA's).

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On 10/05/2017 at 11:47 a.m. nursing assistant (NA)-B stated she was usually a restorative aide and she had been working the floor for the last two weeks and restorative services had not being provided to the residents with scheduled programs.

On 10/05/2017, at 12:29 p.m. the director of nursing (DON) stated when the restorative aides are pulled to cover the floor, there is not a staff member covering restorative services. The DON stated staffing is tough all over and we have even asked if we should have the aides doing range of motion services. The DON stated part of the reason the restorative services were not being done was because of staffing. The facility had a restorative aide retire and a restorative aide went on maternity leave and did not return to work.

On 10/5/17, at 1:05 p.m. registered nurse (RN)-B stated we do not have the staffing to provide the restorative program. The restorative aides that are scheduled to provide restorative nursing services are being pulled to work on the floor. RN-B stated used to have consistent staff in place and restorative meetings regularly. The last restorative meeting we had was on 5/3/17. RN-B stated the main restorative aide retired, one restorative aide was on maternity leave and did not return to work. RN-B stated the facility currently had two restorative aides. RN-B residents were supposed to be having programs five days a week. We are lucky if they provide the service two days a week. RN-B stated the facility was trying to hire more staff. RN-B stated the facility planned to have a meeting as soon as possible to evaluate the residents on the program to see if the current program was still appropriate, if it needed to be updated and to see if therapy

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needed to get involved again. RN-B stated the facility was looking at having a meeting to determine how the facility will proceed with the restorative program because if the restorative aides are being pulled to cover the floor the program was not working.

On 10/05/2017, at 1:33 p.m. the DON stated she spoke with registered nurse (RN)-B and the restorative program was, "pretty much nonexistent at this time."

On 10/05/2017, at 2:12 p.m. registered nurse (RN)-A stated the restorative aides are being assigned to work on the floor right now. RN-A stated when the restorative aides are pulled to the floor, restorative services are not being provided to the residents. RN-A stated there were twenty-four long-term care residents that received restorative services. RN-A stated if there was a call in they (the restorative aides) would get pulled to the floor. There is no other way to fix it.

On 10/06/2017 at 10:23 a.m. staff coordinator (SC)-A stated she was responsible for the staff scheduling for the facility. SC-A stated the facility used a bunch of pool staff to help cover the hours. SC-A stated the restorative aides are pulled to the floor when she cannot cover the hours. SC-A stated mandating of staff, up scheduling of staff and overtime were all being used to cover the open hours.

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St.Mark's Lutheran Home) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/31/2017

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.

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K 000	Continued From page 1 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 is protected by a full fire sprinkler system. 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	K 000		

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K 000	Continued From page 2 census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	K 222		11/15/17

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K 222	Continued From page 3 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222	Egress Door: All doors are on a weekly check on the Tels System. The door which the delayed egress was not working is in the process of being fixed by fox electric. this will be completed by November 6th, 2017.	

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K 222	Continued From page 4 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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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
K 222	Continued From page 5 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10-4-2017, based on observation and interview revealed that the following include: That the delay egress lock in the Memory Care Wing did not operate when tested. This deficient practice could affect the safety of all (20) of 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 222		