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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OOLX

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 **04/01/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

On April 1, 2013 and March 21, 2013, the Departments of Health and Life Safety Code (LSC) completed Post Certification Revisits to verify correction of deficiencies issued pursuant to the standard survey, effective March 26, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective March 26, 2013, the facility is certified for 61 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NEII 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/22/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
POSTED 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5369

May 22, 2013

Mr. Chris Schulz, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 55912

Dear Mr. Schulz:

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 March 26, 2013 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2013

Mr. Chris Schulz, Administrator Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 55912

RE: Project Number S5369022

Dear Mr. Schulz:

On March 1, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 26, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2013, effective March 26, 2013 and therefore remedies outlined in our letter to you dated March 1, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
email: mark.meath@state.mn.us

Enclosure
cc: Licensing and Certification File 5369r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245369	A. Building B. Wing	4/1/2013

Name of Facility	Street Address, City, State, Zip Code
ST MARKS LUTHERAN HOME	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/26/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/26/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	04/08/2013	10155	04/01/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/15/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245369	A. Building B. Wing **01 - MAIN BUILDING 01**	3/21/2013

Name of Facility	Street Address, City, State, Zip Code
ST MARKS LUTHERAN HOME	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/18/2013**	ID Prefix	Correction Completed **02/25/2013**	ID Prefix	Correction Completed **02/20/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0014		LSC K0018	
ID Prefix	Correction Completed **02/25/2013**	ID Prefix	Correction Completed **02/20/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0029		LSC K0062		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By _____ **State Agency**	**Reviewed By** MM/PS	**Date:** 04/08/2013	**Signature of Surveyor:** 25822	**Date:** 03/21/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/14/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OOLX

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: **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 **02/15/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	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):

At the time of the February 15, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NEII 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/05/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/5/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9332

March 1, 2013

Mr. Chris Schulz, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 55912

RE: Project Number S5369022, H5369051

Dear Mr. Schulz:

On February 15, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 15, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5369051 that was found to be unsubstantiated.

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:

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

<u>Plan of Correction</u> - 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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (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 March 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 26, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 15, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

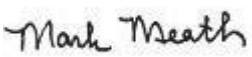
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



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

Enclosure

cc: Licensing and Certification File 5369s13.rtf

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

RECEIVED
MAR 18 2013
MN Dept of Health
Rochester

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	02/15/2013

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5369051 had not been substantiated during this survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225 03-19-13 JPN	F225 Background Studies— The facility failed to ensure background study was completed prior to new employees having unsupervised direct care of residents for 2 of 5 employees reviewed during abuse prohibition. It is the policy of St. Marks to await the completion of the background study prior to allowing newly hired employees to have unsupervised direct care of residents. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits	3-26-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Lorig | TITLE: Administrator | (X6) DATE: 03/15/13

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

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure background study was completed prior to new employees having unsupervised direct care of residents for 2 of 5 employees (E1, E2) reviewed during abuse prohibition. Findings include: E1 was hired on 11/14/12. The employee schedule indicated was working with residents' four shifts prior to background study findings completed. The date on the background study indicated 11/19/12 the study was submitted.	F 225	will be completed and brought to the QA meeting for review by the Quality Assurance Team. The QA committee will determine when to stop auditing. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. DON responsible.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 2 E2 was hired on 12/21/12. The employee schedule indicated was working with residents' one shift prior to background study findings being completed. The date on the background study indicated 12/27/12 the study was submitted. During interview on 2/13/13 at 2:36 p.m., human resources director (HRD) verified the background study for E1 and E2 findings was not back before they had direct unsupervised contact with residents in the facility. HRD confirmed background checks were to be done right away when hired. HRD said that they typically have had the background check completed and then the staff would start one week later. During interview on 2/14/13 at 12:05 p.m., the executive director verified human resources was responsible for completing the background checks and were supposed to be done before resident contact. During interview on 2/14/13 at 12:58 p.m., assistant director of nursing brought in a sheet and indicated background checks are part of the orientation process. Policy for completing background studies was requested on 2/14/13 and none had been received from facility.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	F279 Care Planning/Discharge Planning—The facility failed to develop a care plan that addressed discharge planning for 1 of 2 residents reviewed for discharge from facility. It is the policy of St. Marks to complete a care plan for each	3-26-13

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F 279	Continued From page 3 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a care plan that addressed discharge planning for 1 of 2 residents (R95) reviewed for discharge from facility. Findings include: R95 did not have a care plan which addressed discharge planning and interventions. R95 was admitted on 11/15/2012 with diagnoses which included but not limited to: hypertension, renal insufficiency, pneumonia, history of falls, obesity, and hemiplegia related a stroke. R95's care plan dated 1/11/2013 was reviewed. It noted: Resident strength, here for short term rehabilitation and able to make own decisions,	F 279	resident which includes discharge planning and interventions. Care Plan for resident R95 was reviewed and updated on 2-11-13. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits will be completed and brought to the QA meeting for review by the Quality Assurance Team. The QA committee will determine when to stop auditing. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. DON responsible.	

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F 279	Continued From page 4 choices and benefits from independence of those choices. The care plan did not address discharge planning or intervention for continued strengthening exercises or ambulating, or if these services were to be provided on an outpatient basis or if home health would be seeing him for monitoring and rehabilitative interventions. On 2/13/2013 at 10:25 a.m. and 11:00 a.m., the licensed social worker was interviewed regarding discharge planning for R95. The resident came in with a stroke, had occupational therapy and physical therapy. The goal was to get R95 home. The expectation was the discharge planning would be on the care plan. However, this had not been completed.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 Care Conferences—The facility failed to invite family and resident to participate in care conference for 2 of 3 residents reviewed for participation in care planning. It is the policy of St. Marks to invite family and resident to participate in care conference and care planning. Care conferences were completed for R43 on 3-6-13 and R53 on 3-11-13. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits will be completed and brought to the QA meeting for review by the Quality Assurance Team. The QA	3-26-13

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to invite family and resident to participate in care conference for 2 of 3 residents (R53 and R43) reviewed for participation in care planning. Findings include: R55 ' s family (F)-A was interview on 2/12/13, at 8:13 a.m. and had been asked if she had been invited to participate in R53's care planning conferences? F-A verified she had not been invited to attend care conference and added that the facility was no longer having care conferences unless a request was made by family. R53 had a diagnosis of cerebral degenerations and was admitted on 10/4/12. Review of the resident's medical record revealed no documentation to show an interdisciplinary care conference had been held since admission to the facility with R53 or her family (a time period of 4 months). In addition there was no documentation to show the interdisciplinary team had met as a team to review R53's plan of care since admission. During an interview on 2/14/13, at 11:22 a.m. the director of clinical services (DOCS) verified the facility was unable to provide documentation to show care conferences were held for R53 since admission to the facility.	F 280	committee will determine when to stop auditing. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. DON responsible.	3

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F 280	Continued From page 6	F 280		

R43 had diagnoses of chronic ischemic heart disease and was admitted several years previously. Review of resident's medical revealed R43's last care conference was held on 8/14/12 (five months from last care conference to survey date).

During an interview on 2/14/13, at 11:19 a.m. DOCS verified there was no documentation to show care conferences were held for R43 since 8/14/12. The DOCS stated she would look for documentation for the care conference that should have been held for R43 in November 2012 following the comprehensive assessment as one should have been held as care conferences were not discontinued until 12/1/12.

During an interview on 2/13/13, at 10:05 a.m. DORS stated in November 2012 a nurse consultant informed the facility that regular care conferences were no longer required. The DORS stated the facility involved residents in the care planning process by the residents participating in the face to face interviews that are done through the comprehensive assessment process for the Minimum Data Assessment (MDS). The DORS stated families were made aware they are able to request a care conference at any time. The DORS stated a letter was sent out to all of the families notifying them of the facility change in the facility change in care conference process in November 2012.

During an interview on 2/13/13, at 12:50 p.m. DOCS stated the regulation for care conferences did not state you need to have a sit down meeting

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F 280	Continued From page 7 with residents or families. The DOCS stated as long as departments communicated to the resident and their families regarding their discipline no formal care conference meeting was required. However, the DOCS verified the facility was unable to show documentation the departments had been communicating to the resident and their families since the facility made the change to no longer have scheduled care conferences. Review of the Care Conference policy dated June 2011, indicated, " a. At a minimum, care conferences are held within 7 days after completing or reviewing the comprehensive assessment, quarterly, annually, and with a significant change in status. b. Upon request of the resident or representative." During an interview on 2/14/13, at 1:22 p.m. the DOCS verified the facility was not following the Care Conference policy dated June 2011.	F 280		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	F329 Unnecessary Drugs— The facility failed to ensure a comprehensive sleep assessment was completed before starting as needed (PRN) antianxiety medication used as a hypnotic was used for 1 of 1 residents in the sample who had Ativan ordered for sleep; and the facility failed to provide non-pharmacological interventions prior to giving PRN pain medication and/or failed to document if pain medication was effective for	3-26-13

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F 329	Continued From page 8 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive sleep assessment was completed before starting as needed (PRN) antianxiety medication used as a hypnotic was used for 1 of 1 resident (R106) in the sample who had Ativan ordered for sleep; and the facility failed to provide non-pharmacological interventions prior to giving PRN pain medication and/or failed to document if pain medication was effective for pain control for 2 0f 10 residents (R74, R1) reviewed for unnecessary medication; and failed to ensure the use of Seroquel (an antipsychotic) was monitored for causing tardive dyskinesia symptoms for 1 of 10 residents (R6) currently receiving daily dose of Seroquel. Findings include: R106 received an as necessary antianxiety medication to induce sleep with no evidence of a sleep assessment to identify potential causative factors or to identify non-pharmacological interventions to promote sleep prior to initiation of	F 329	pain control for 2 of 10 residents reviewed for unnecessary medication; and failed to ensure the use of Seroquel (an antipsychotic) was monitored for causing tardive dyskinesia symptoms for 1 of 10 residents currently receiving daily dose of Seroquel. It is the policy of St. Marks that residents who have an order for as needed (PRN) hypnotics for sleep have a comprehensive sleep assessment completed prior to initiating use of the medication. It is the policy of St. Marks that residents with as needed (PRN) orders for pain medication have non-pharmacological interventions provided prior to giving PRN pain medication and that such interventions will be documented as to the results of the use of the intervention/and or medication as utilized. It is the policy of St. Marks that all PRN medications have documentation as to the effectiveness of the medication used. It is the policy of St. Marks that residents receiving antipsychotic medications are monitored for symptoms of Tardive Dyskinesia per policy.	

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F 329	Continued From page 9 the medication. R106 was admitted to the facility in 1/29/2013 with diagnoses including: new surgical colostomy, atrial fibrillation, depression, and peripheral vascular disease. A hospital discharge summary dated 1/29/2013 was reviewed. It noted a physician order for Ativan (antianxiety medication) 0.5 mg. every 6 hours as needed for nausea/sleep. Further review of the medical record, revealed the medication was started with no evidence of a sleep assessment to identify actual or potential causes of a sleep problem, or evaluate non-pharmacological intervention to promote sleep. The care plan (review date 1/29/2013), did not include insomnia and non-pharmacological interventions to address sleep. Further review revealed no evidence of ongoing monitoring of sleep quality or hours of sleep to determine if the medication was effective. The psychotropic/other medication assessment form dated 2/4/2013 was reviewed. It identified Lorazepam (Ativan) medication 0.5 mg every 6 hours for nausea and to aid with sleep. It identified the target behavior occurred 4-5 x per month and the severity was moderate. It did not address underlying medical or environmental causes contributing to insomnia as being reviewed. It did identify "non-drug" interventions had not been tried. The goal was to improve sleeping pattern. Registered nurse (RN)-B a nurse manager was interviewed on 2/14/2013 at 10:00 a.m., and explained when she questioned R106, regarding	F 329	Resident R106 on the sited list has discharged from the facility. Resident R74 has been discharged from the facility. Resident R1 care plan reviewed and updated to include non-pharmacological interventions for pain on 2-26-13. Resident R6 has had Tardive Dyskinesia assessment completed on 2-15-2013. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits will be completed and brought to the QA meeting for review by the Quality Assurance Team. The QA committee will determine when to stop auditing. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. DON responsible.	

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F 329	Continued From page 10 how many hours of sleep the resident got each night, the resident told her 4-5 hours and would wait until after midnight to ask for the sleeping medication. RN-B indicated the Ativan had been given 3-4 x's per week prior to admission and that has continued since admission. RN-B said they have not tried non-pharmacological interventions. RN-B stated the staff was to document effectiveness of the medication when given on the medication sheet. Since admission, the resident had used Ativan 10 times and some of those times it was given for nausea. However, when the Ativan was used for nausea it had not been documented it was for this purpose. R74 was admitted to the facility 1/10/13 and had medical diagnoses that included but not limited to congestive heart failure, respiratory abnormality, backache. The current physician orders listed as needed Ativan (antianxiety medication) for anxiety; as needed Tramadol for pain. Review of the medication administration record (MAR) revealed R74 had received PRN Tramadol 36 times during January 10th through January 31st time period and Tramadol was given 23 times. Out of the 23 times the Tramadol was given there was no documentation regarding results or effectiveness of the pain medication. During review of January MAR and nurse ' s medication notes R74 had received as needed Ativan six times and was for resident request and not what symptoms of anxiety was noted, staff documented effectiveness one time out of a total of six. During review of the MAR for the month of February R74 had received Tramadol four times with effectiveness documented only once. Also for the month of February R74 had received	F 329		

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F 329	Continued From page 11 Ativan four times with effectiveness documented once. There were no non-pharmacological interventions documented prior to giving the PRN Ativan and Tramadol medications. During interview on 2/13/13 at 10:32 a.m., licensed practical nurse (LPN)-A indicated the Ativan was a PRN order and was given upon resident request. LPN-A verified if the resident requests a medication it was given without looking at non- pharmacological interventions. R1 had medical diagnoses that included but not limited to congestive heart failure, chronic kidney disease and obesity. The current physician orders listed PRN Tramadol. Review of the medication administration record (MAR) revealed R1 had received PRN Tramadol 5 times during January 2013 and three times had effectiveness charted out of five. Also for the month of January 2013 Tylenol 650 milligrams was given one time and no effectiveness documented. During review of the MAR for the month of February R1 had received Tramadol two times with effectiveness documented zero times. There were no non-pharmacological interventions documented prior to giving the PRN pain medications. During interview on 2/13/13 at 1:29 p.m., RN-B verified nursing staff were supposed to follow up within an hour or two after a PRN medication was given to determine if the medication was effective or not. RN-B indicated non-pharmacological interventions would be in the nursing notes. However, none were noted.	F 329		

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F 329	Continued From page 12 During interview on 2/13/13 at 1:11 p.m., the director of clinical services indicated the expectation was for all nurses to document the effectiveness of the pain as needed pain medications within an hour or two. During interview on 2/13/13 at 1:43 p.m., RN-A indicated the non-pharmacological attempts would be in the nurses notes. Staff should try to attempt non-pharmacological interventions before giving PRN and would expect documentation in the MAR or the nurse ' s notes. During Pain Management policy review dated 5/11 the policy directed staff PRN pain medication given was signed off on the medication administration record and resident was to be monitored after a PRN was given and effectiveness documented. R6 lacked an assessment for possible tardive dyskinesia symptoms while taking Seroquel an antipsychotic medication with high potential of causing tardive dyskinesia (abnormal movements that don ' t subside with medication changes.) R6 was admitted to the facility 2/20/12, with diagnosis that included dementia, Parkinson ' s disease, anxiety and depression. The facility identified R6 on the quarterly minimum data set (MDS) dated 11/16/12, to have moods and behaviors, severe cognitive impairment, and received antipsychotic and anti-depressant medication. During observations on 2/14/13, at 9:05 a.m., R6 sat in a lounge chair in his room with television	F 329		

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	245369	A. BUILDING _____ B. WING _____	02/15/2013

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F 329	Continued From page 13 on. No behaviors were noted at that time. Document review of physician orders dated 2/1/13-2/28/13, for seroquel (antipsychotic medication) 12.5 milligrams at bedtime. Document review of the facility Dyskinesia Identification System (DISCUS), an assessment for symptoms of tardive dyskinesia, dated 6/18/12, revealed no symptoms were noted. The assessment indicated the next assessment was due 12/18/12. The facility lacked evidence of any further assessment for tardive dyskinesia since 6/18/12, a period of eight months since the last assessment was conducted. Document review of the consultant pharmacist ' s medication regimen review recommendation dated 1/30/13, identified R6 received Seroquel, the last DISCUS assessment for symptoms of tardive dyskinesia, was dated 6/18/12, and recommended R6 was due for another DISCUS assessment. During interview on 2/14/13, at 2:50 p.m., registered nurse-B (RN-B) stated the tardive dyskinesia assessment was due 12/18/12. RN-B verified she was aware of the consultant pharmacist recommendation that the DISCUS was due. RN-B verified the facility had no evidence the DISCUS assessment had been completed since 6/18/12. RN-B stated she expected the assessment to be completed every six months. Document review of the facility Tardive Dyskinesia policy review date of 5/2011, directed, " Individuals who are prescribed antipsychotics or	F 329		

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F 329	Continued From page 14 other medication with Tardive Dyskinesia (TD) as a possible side effect are regularly and systematically assessed and evaluated for TD. Individuals who have tardive dyskinesia are regularly and systematically assessed and evaluated in regard to the status of the tardive dyskinesia," and, #1. d. "Ongoing TD screenings occur at least once every six months."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served in a sanitary manner for the noon meal and supper meal located in the main dining room and the transitional care dining room. This had the potential to affect 52 of 52 residents in the facility. Findings include: During the evening meal service on 2/11/13 the following was observed: At 5:26 p.m., 4 room trays were prepared from	F 371	F371 Infection Control/Food Handling—The facility failed to ensure food was served in a sanitary manner for the noon meal and supper meal located in the main dining room and the transitional care dining room. This has the potential to affect 52 of 52 residents in the facility. It is the policy of St. Marks that food is served in a sanitary manner. This includes but is not limited to staff using proper utensils and/or gloves when handling foods, wash hands before handling of foods, and avoid touching face and mouth while preparing food. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits will be completed and brought to the QA meeting for review by the Quality	3-26-13

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F 371	Continued From page 15 the dining room steam table. The supper meal included hot pork sandwich, cold beef sandwich, cauliflower, peas and carrots, and baked potato. At 5:47 p.m., nursing assistant (NA)-E pulled up their slacks, touched their hair with bare hands, asked 2 residents for menu orders, then touched right ear, placed their right arm around a resident ' s shoulders, asked this resident for menu order, and then returned to the steam table with order for both residents. While at steam table waiting for set up of food, NA-E touched hair and face with bare hand. Without sanitizing bare hands NA-E held unto the plate of food to deliver it to a resident. Then proceeded to hold the pork sandwich with soiled hand to cut it in pieces for the resident. From 5:52 to 6:02, NA-E was observed to touch wheelchair wheels, scratch face, play with hair, scratch scalp and without sanitizing hands delivered coffee to a resident, cut up two pork sandwiches for two residents. During evening meal observations on the transitional care unit on 2/11/13, starting at 5:15 p.m. dining assistant (AD)-A while wearing gloves, pushed the steam table into the dining room and without changing gloves or sanitizing hands began to placed food from the steam table onto plates, including the touching of the buns while wearing the soiled gloves. While dishing up the meal with the soiled gloves AD-A was observed to opened doors of a cart, pulled out food trays, touched buns and unpeeled bananas. Observations of the noon meal in the main dining room on 2/13/13, at 12:05 p.m., NA-B touched a	F 371	Assurance Team. The QA committee will determine when to stop auditing. Communication sent to all staff on 2/20/13 regarding safe food handling. Dietary staff educated by Dietary Director on2-28-13. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. Annual Infection Control Training has been updated to include food service information. DON responsible.	

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F 371	Continued From page 16 bun with bare hands to cut the bun. NA-B had not sanitized hands nor put on gloves before touching the bun. The bun was then served to a resident. During interview on 2/13/13, at 1:50 p.m., certified dietary manager (CDM) stated she expected staff to use hand sanitizer or wear gloves before touching food. CDM stated she expected staff to use hand sanitizer or change gloves if touched other than food. The CDM stated although the facility conducted infection control training, the training lacked food service infection control. During interview on 2/14/13, at 9:30 a.m., assistant director of nursing (ADON)/infection control nurse stated she was not aware of a concern with a lack of infection control practices with dining service. ADON stated that she expected staff to wash hands, use hand sanitizer, and change gloves when contaminated. She verified dining service included dietary cooks who placed food onto plates and nursing staff who delivered plates to residents. She verified the facility infection control training lacked food service infection control education. Document review of the facility food handling policy, review date of 5/2011, identified nursing and dietary were responsible for the policy. The facility policy directed staff to use proper utensils and/or gloves when handling foods, wash hands before handling of foods, and avoid touching face and mouth while preparing food.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431 Proper labeling of medications—The facility failed to ensure medications were properly labeled for 1 of 10 residents reviewed during	3-26-13

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F 431	Continued From page 17 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure medications were properly labeled for 1 of 10 residents (R104) reviewed during medication pass.	F 431	medications pass. It is the policy of St. Marks that medications be properly labeled. This includes but is not limited to the following information: Generic name of product, Common brand name (as needed), Dosage form and strength, Lot number, Expiration date, Appropriate auxiliary label, Bar code based on the National Drug Code. Resident R104 medication sited was removed from the medication cart on 2-13-13 and has been destroyed by DON and pharmacy on 3-7-13. To ensure future compliance this has been incorporated into the St. Marks QA process. Audits will be completed and brought to the QA meeting for review by the Quality Assurance Team. The QA committee will determine when to stop auditing. All staff will be educated on 3/21/13 at the All Staff Inservice. DON responsible for overall compliance for Inservice and monitoring of staff training. Facility care expectations will be in compliance by 3/26/13. DON responsible.	

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F 431	Continued From page 18 Findings include: During observation on 2/12/13 at 8:15 a.m., licensed practical nurse (LPN)-A pulled out a Ziploc bag with no pharmacy label but was marked as Hydromorphine (a potent pain medication) and no other information on the bag as to the dose, time to give, no name of resident, and outdates. On an interview during this time with the LPN at the time had 12 small pills. LPN-A indicated R104 was on hospice and the hospice nurse split the pills and put the pills in the Ziploc bag. LPN-A confirmed there was no pharmacy label to identify what medication was in the bag. On 2/12/13 at 12:48 p.m., received a copy of the Ziploc bag and the health unit coordinator indicated the medication was going to be disposed of and R104 had a new medication order. During interview on 2/14/13 at 10:24 a.m., the director of clinical services indicated the medication should have been destroyed and reordered from the pharmacy with a label on. During interview on 2/14/13 at 1:53 p.m., the consultant pharmacist confirmed the medication was brought in by hospice and should have had a label on the bag to identify the medication, how old the medication was, the strength of the medication, prescription number. The consultant pharmacist indicated in general, the medication should have been split and placed back in the medication bottle with the pharmacy label. During an interview on 2/14/13 at 2:24 p.m., the	F 431		

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F 431	Continued From page 19 hospice registered nurse verified keeping medications in a Ziploc without a proper label was not a hospice practice. The hospice nurse indicated when at the facility on Tuesday, the facility nurse was instructed the medications in the Ziploc were to be counted and destroyed as medication cannot be kept in a Ziploc bag, as that was not acceptable practice due to the medication not properly labeled. The hospice nurse confirmed the medication bottle was removed from the facility and taken to the pharmacy to have the drug identified and to ensure the tablets were half tablets like R104's new order. The hospice nurse indicated was unsure where the Ziploc bag with the medications came from, the facility had a bottle that was correctly labeled for use. During review of Mayo Health System Austin's Hospice policy regarding medication labeling dated 7/2012 directed staff, "Whenever possible, unit dose medications are purchased from the manufacturer to ensure proper labeling. Products that are only available in bulk, or are considerably more expensive when purchased in unit dose form, are packaged in unit dose and labeled with the following information: Generic name of product, Common brand name (as needed), Dosage form and strength, Lot number, Expiration date, Appropriate auxiliary label, Bar code based on the National Drug Code."	F 431		

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

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, St. Mark's Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok TB 3-26-13 RECEIVED MAR 19 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 3-26-13

EXIT: 2-15-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Schaefer	Administrator	03/15/13

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

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@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. 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. The building meets the construction type allowed for existing buildings, the facility was surveyed as a Type V (111) building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is	K 000		

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect all 15 out of 55 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 02/14/2013, observation revealed, that the 2-hour rated building separation double doors between nursing home and north assisted living did not shut and latch because upper door hinge is not secured to door. This deficient practice was confirmed by Director	K 011	K011 Per NFPA 101, sections 19.1.1.4.1 and 8.2.3.2 a two- hour fire resistance rating construction was ordered and will be installed the week of March 18th, 2013 (see attached documentation).	

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K 011	Continued From page 3 of Environmental Services (BR) at the time of discovery.	K 011		
K 014 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meet the flame spread requirements of 2000 NFPA 101, Sections 19.3.3.1, 19.3.3.2 and 10.2.3. The deficient practice could affect all 55 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 02/14/2013, observation revealed that in the basement corridor by the soiled linen room there are several floor to ceiling plastic wall covering panels. The facility has no flame spread rating documentation for these plastic material on the walls. This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery.	K 014	**K014** Per NFPA 101, sections 19.3.3.2, 19.3.3.2 and 10.2.3 the facility removed the interior finish materials that did not meet the flame spread requirement on February 25, 2013.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018		

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K 018	Continued From page 4 hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD Is not met as evidenced by: Based on observation and staff interview, the facility has corridor doors that do not latch into their frames in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect 15 out 55 out residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 12:30 PM on 02/14/2013, observation revealed that the basement - maintenance storage rooms # 1 and 2 (which opens into the corridor) do not have positive latching hardware.	K 018	**K018** Per NFPA 101, sections 19.3.6.3.2 the maintenance storage rooms #1 and #2 doors were fixed with positive latching hardware on February 20, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2013

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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K 018	Continued From page 5 This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 55 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 02/14/2013, observation revealed that the basement main storage room over 50 square feet, has open penetrations on south and east walls around pipes and cables.	K 029	**K029** Per NFPA 101, sections 19.3.2.1 the open penetrations on the south and east walls in the basement main storage room were filled with approved fire caulk on February 25, 2013.	

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	245369	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/14/2013

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K 029	Continued From page 6 This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1. This deficient practice could affect all 55 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 02/14/2013, the review of the annual fire sprinkler inspection report from Summit Fire Protection revealed that the inspection was not completed in a 12 month period. 2012 was done on 01/24/2012 and 2013 has not been completed at the time of the survey. This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery.	K 062	**K062** Per NFPA 101, sections 19.3.4.1 and 9.6 as well as 1998 NFPA 25, section 2-2.1.1 the facility contacted Summit Fire Protection and an inspection of our sprinkler system was completed on February 20, 2013. This will be an annual inspection happening on or before February 20th. Environmental Services Director will monitor for compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 062	Continued From page 7 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9332

March 1, 2013

Mr. Chris Schulz, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 55912

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5369022, H5369051

Dear Mr. Schulz:

The above facility was surveyed on February 11, 2013 through February 15, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5369051. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

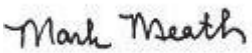
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately Gary Nederhoff at (507) 206-2731.

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

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

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

Sincerely,



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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING _____ B. WING _____	02/15/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 11, 12, 13, 14, and 15, 2013 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904. A standard recertification survey and state licensing survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey/licensing order. An investigation of complaint H5369051 had not been substantiated during this survey.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced	2 560		

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2 560	Continued From page 2 by: Based on interview, and document review, the facility failed to develop a care plan that addressed discharge planning for 1 of 2 residents (R95) reviewed for discharge from facility. Findings include: R95 did not have a care plan which addressed discharge planning and interventions. R95 was admitted on 11/15/2012 with diagnoses which included but not limited to: hypertension, renal insufficiency, pneumonia, history of falls, obesity, and hemiplegia related a stroke. R95's care plan dated 1/11/2013 was reviewed. It noted: Resident strength, here for short term rehabilitation and able to make own decisions, choices and benefits from independence of those choices. The care plan did not address discharge planning or intervention for continued strengthening exercises or ambulating, or if these services were to be provided on an outpatient basis or if home health would be seeing him for monitoring and rehabilitative interventions. On 2/13/2013 at 10:25 a.m. and 11:00 a.m., the licensed social worker was interviewed regarding discharge planning for R95. The resident came in with a stroke, had occupational therapy and physical therapy. The goal was to get R95 home. The expectation was the discharge planning would be on the care plan. However, this had not been completedF279 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct	2 560		

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2 560	Continued From page 3 staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served in a sanitary manner for the noon meal and supper meal located in the main dining room and the transitional care dining room. This had the potential to affect 52 of 52 residents in the facility. Findings include: During the evening meal service on 2/11/13 the following was observed: At 5:26 p.m., 4 room trays were prepared from the dining room steam table. The supper meal included hot pork sandwich, cold beef sandwich, cauliflower, peas and carrots, and baked potato. At 5:47 p.m., nursing assistant (DNA)-E pulled up their slacks, touched their hair with bare hands,	21015		

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21015	Continued From page 4 asked 2 residents for menu orders, then touched right ear, placed their right arm around a resident ' s shoulders, asked this resident for menu order, and then returned to the steam table with order for both residents. While at steam table waiting for set up of food, NA-E touched hair and face with bare hand. Without sanitizing bare hands NA-E held unto the plate of food to deliver it to a resident. Then proceeded to hold the pork sandwich with soiled hand to cut it in pieces for the resident. From 5:52 to 6:02, NA-E was observed to touch wheelchair wheels, scratch face, play with hair, scratch scalp and without sanitizing hands delivered coffee to a resident, cut up two pork sandwiches for two residents. During evening meal observations on the transitional care unit on 2/11/13, starting at 5:15 p.m. dining assistant (AD)-A while wearing gloves, pushed the steam table into the dining room and without changing gloves or sanitizing hands began to placed food from the steam table onto plates, including the touching of the buns while wearing the soiled gloves. While dishing up the meal with the soiled gloves AD-A was observed to opened doors of a cart, pulled out food trays, touched buns and unpeeled bananas. Observations of the noon meal in the main dining room on 2/13/13, at 12:05 p.m., NA-B touched a bun with bare hands to cut the bun. NA-B had not sanitized hands nor put on gloves before touching the bun. The bun was then served to a resident. During interview on 2/13/13, at 1:50 p.m., certified dietary manager (CDM) stated she expected staff to use hand sanitizer or wear gloves before touching food. CDM stated she expected staff to	21015		

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21015	Continued From page 5 use hand sanitizer or change gloves if touched other than food. The CDM stated although the facility conducted infection control training, the training lacked food service infection control. During interview on 2/14/13, at 9:30 a.m., assistant director of nursing (ADON)/infection control nurse stated she was not aware of a concern with a lack of infection control practices with dining service. ADON stated that she expected staff to wash hands, use hand sanitizer, and change gloves when contaminated. She verified dining service included dietary cooks who placed food onto plates and nursing staff who delivered plates to residents. She verified the facility infection control training lacked food service infection control education. Document review of the facility food handling policy, review date of 5/2011, identified nursing and dietary were responsible for the policy. The facility policy directed staff to use proper utensils and/or gloves when handling foods, wash hands before handling of foods, and avoid touching face and mouth while preparing food. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The designated Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 6 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive sleep assessment was completed before starting as needed (PRN) antianxiety medication used as a hypnotic was used for 1 of 1 resident (R106) in the sample who had Ativan ordered for sleep; and the facility failed to provide non-pharmacological interventions prior to giving PRN pain medication and/or failed to document if pain medication was effective for pain control for 2 of 10 residents (R74, R1) reviewed for unnecessary medication; and failed to ensure the	21535		

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21535	Continued From page 7 use of Seroquel (an antipsychotic medication) was monitored for causing tardive dyskinesia symptoms for 1 of 10 residents (R6) currently receiving daily dose of Seroquel. Findings include: R106 received an as necessary antianxiety medication to induce sleep with no evidence of a sleep assessment to identify potential causative factors or to identify non-pharmacological interventions to promote sleep prior to initiation of the medication. R106 was admitted to the facility in 1/29/2013 with diagnoses including: new surgical colostomy, atrial fibrillation, depression, and peripheral vascular disease. A hospital discharge summary dated 1/29/2013 was reviewed. It noted a physician order for Ativan (antianxiety medication) 0.5 mg. every 6 hours as needed for nausea/sleep. Further review of the medical record, revealed the medication was started with no evidence of a sleep assessment to identify actual or potential causes of a sleep problem, or evaluate non-pharmacological intervention to promote sleep. The care plan (review date 1/29/2013), did not include insomnia and non-pharmacological interventions to address sleep. Further review revealed no evidence of ongoing monitoring of sleep quality or hours of sleep to determine if the medication was effective. The psychotropic/other medication assessment form dated 2/4/2013 was reviewed. It identified Lorazepam (Ativan) medication 0.5 mg every 6 hours for nausea and to aid with sleep. It identified the target behavior occurred 4-5 x per	21535		

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21535	Continued From page 8	21535		

month and the severity was moderate. It did not address underlying medical or environmental causes contributing to insomnia as being reviewed. It did identify "non-drug" interventions had not been tried. The goal was to improve sleeping pattern.

Registered nurse (RN)-B a nurse manager was interviewed on 2/14/2013 at 10:00 a.m., and explained when she questioned R106, regarding how many hours of sleep the resident got each night, the resident told her 4-5 hours and would wait until after midnight to ask for the sleeping medication. RN-B indicated the Ativan had been given 3-4 x's per week prior to admission and that has continued since admission. RN-B said they have not tried non-pharmacological interventions. RN-B stated the staff was to document effectiveness of the medication when given on the medication sheet. Since admission, the resident had used Ativan 10 times and some of those times it was given for nausea. However, when the Ativan was used for nausea it had not been documented it was for this purpose.

R74 was admitted to the facility 1/10/13 and had medical diagnoses that included but not limited to congestive heart failure, respiratory abnormality, backache. The current physician orders listed as needed Ativan (antianxiety medication) for anxiety; as needed Tramadol for pain.

Review of the medication administration record (MAR) revealed R74 had received PRN Tramadol 36 times during January 10th through January 31st time period and Tramadol was given 23 times. Out of the 23 times the Tramadol was given there was no documentation regarding results or effectiveness of the pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING _____ B. WING _____	02/15/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 9 During review of January MAR and nurse ' s medication notes R74 had received as needed Ativan six times and was for resident request and not what symptoms of anxiety was noted, staff documented effectiveness one time out of a total of six. During review of the MAR for the month of February R74 had received Tramadol four times with effectiveness documented only once. Also for the month of February R74 had received Ativan four times with effectiveness documented once. There were no non-pharmacological interventions documented prior to giving the PRN Ativan and Tramadol medications. During interview on 2/13/13 at 10:32 a.m., licensed practical nurse (LPN)-A indicated the Ativan was a PRN order and was given upon resident request. LPN-A verified if the resident requests a medication it was given without looking at non- pharmacological interventions. R1 had medical diagnoses that included but not limited to congestive heart failure, chronic kidney disease and obesity. The current physician orders listed PRN Tramadol. Review of the medication administration record (MAR) revealed R1 had received PRN Tramadol 5 times during January 2013 and three times had effectiveness charted out of five. Also for the month of January 2013 Tylenol 650 milligrams was given one time and no effectiveness documented. During review of the MAR for the month of February R1 had received Tramadol two times with effectiveness documented zero times. There were no non-pharmacological interventions documented prior to giving the PRN pain medications. During interview on 2/13/13 at 1:29 p.m., RN-B	21535		

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21535	Continued From page 10 verified nursing staff were supposed to follow up within an hour or two after a PRN medication was given to determine if the medication was effective or not. RN-B indicated non-pharmacological interventions would be in the nursing notes. However, none were noted. During interview on 2/13/13 at 1:11 p.m., the director of clinical services indicated the expectation was for all nurses to document the effectiveness of the pain as needed pain medications within an hour or two. During interview on 2/13/13 at 1:43 p.m., RN-A indicated the non-pharmacological attempts would be in the nurses notes. Staff should try to attempt non-pharmacological interventions before giving PRN and would expect documentation in the MAR or the nurse ' s notes. During Pain Management policy review dated 5/11 the policy directed staff PRN pain medication given was signed off on the medication administration record and resident was to be monitored after a PRN was given and effectiveness documented. R6 lacked an assessment for possible tardive dyskinesia symptoms while taking Seroquel an antipsychotic medication with high potential of causing tardive dyskinesia (abnormal movements that don ' t subside with medication changes.) R6 was admitted to the facility 2/20/12, with diagnosis that included dementia, Parkinson ' s disease, anxiety and depression. The facility identified R6 on the quarterly minimum data set (MDS) dated 11/16/12, to have	21535		

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21535	Continued From page 11 moods and behaviors, severe cognitive impairment, and received antipsychotic and anti-depressant medication. During observations on 2/14/13, at 9:05 a.m., R6 sat in a lounge chair in his room with television on. No behaviors were noted at that time. Document review of physician orders dated 2/1/13-2/28/13, for seroquel (antipsychotic medication) 12.5 milligrams at bedtime. Document review of the facility Dyskinesia Identification System (DISCUS), an assessment for symptoms of tardive dyskinesia, dated 6/18/12, revealed no symptoms were noted. The assessment indicated the next assessment was due 12/18/12. The facility lacked evidence of any further assessment for tardive dyskinesia since 6/18/12, a period of eight months since the last assessment was conducted. Document review of the consultant pharmacist ' s medication regimen review recommendation dated 1/30/13, identified R6 received Seroquel, the last DISCUS assessment for symptoms of tardive dyskinesia, was dated 6/18/12, and recommended R6 was due for another DISCUS assessment. During interview on 2/14/13, at 2:50 p.m., registered nurse-B (RN-B) stated the tardive dyskinesia assessment was due 12/18/12. RN-B verified she was aware of the consultant pharmacist recommendation that the DISCUS was due. RN-B verified the facility had no evidence the DISCUS assessment had been completed since 6/18/12. RN-B stated she expected the assessment to be completed every six months.	21535		

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21535	Continued From page 12 Document review of the facility Tardive Dyskinesia policy review date of 5/2011, directed, "Individuals who are prescribed antipsychotics or other medication with Tardive Dyskinesia (TD) as a possible side effect are regularly and systematically assessed and evaluated for TD. Individuals who have tardive dyskinesia are regularly and systematically assessed and evaluated in regard to the status of the tardive dyskinesia," and, #1. d. "Ongoing TD screenings occur at least once every six months." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the use of psychoactive medications with the licensed staff to meet the requirements of the state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		