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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PPQV

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 **12/11/2013** (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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):
Post Certification Revisit (PCR) of Health and Life Safety Code Surveys completed December 11, 2013. Refer to CMS form 2567B

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 03/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/11/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/20/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245369

March 11, 2014

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 December 3, 2013 the above facility is certified for or recommended for:

61 Skilled Nursing Facility /Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 skilled nursing facility beds located in rooms .

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 11, 2014

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

RE: Project Number S5369023

Dear Mr. Schulz:

On November 7, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 24, 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 December 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 3, 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 October 24, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2013, effective December 3, 2013 and therefore remedies outlined in our letter to you dated November 7, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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	12/11/2013

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 **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/03/2013**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/03/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **12/03/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/03/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/03/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	03/11/2014	31217	12/11/2014
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
10/24/2013			

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	12/3/2013

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 Reg. # NFPA 101 LSC K0029	Correction Completed 11/12/2013	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 11/04/2013	ID Prefix Reg. # NFPA 101 LSC K0071	Correction Completed 10/25/2013
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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	03/11/2014	31217	12/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/23/2013

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: PPQV

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 **10/24/2013** (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

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 Standard survey, the facility was not in substantial compliance with Federal certification regulations. 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 :
Kyla Einertson, HFE NEII 11/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/18/2013 (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

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 5147 5656

November 7, 2013

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

RE: Project Number S5369023

Dear Mr. Schulz:

On October 23, 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.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-271

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 December 3, 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 December 3, 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 January 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2014 (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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/24/2013

NOV 21 2013
MN Dept of Health
Rochester

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000	F248 1. Corrective Action: A. Resident (R110) was interviewed by the Recreation Director and was offered a T.V. or radio for her room. Resident declined both of these. B. Resident (R110) was discharged to home on 10/29/13.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized activity program in order to meet the needs for 1 of 3 residents (R110) reviewed for activities. Findings include: R110 had not been comprehensively assessed for activity interests and then provided an ongoing activity program based on these assessments. R110 was encouraged to attend group activities but R110 refused as she preferred to have activities that were not part of a group setting and	F 248	2. Corrective Action as it applies to Other Residents: A. It is the policy and procedure of St. Mark's to assess for individualized activity preferences and develop a plan of care according to those preferences. 3. Date of Completion: 12/3/2013. 4. Reoccurrence will be Prevented by: A. Staff education and training on the policy and procedure for developing an individualized comprehensive care plan based on the activity preference assessment. B. Audits will be conducted weekly to ensure the care plans and resident assessments are being	

11-21-13 SPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Schug — TITLE: Administrator — (X6) DATE: 11/16/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/24/2013

NOV 21 2013
MN Dept of Health
Rochester

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 248	Continued From page 1 these non-group activities were not fully assessed nor provided. R110 was observed on 10/21/13 at 11:01 a.m., 11:40 a.m., and 1:14 p.m.; 10/22/13 at 8:42 a.m.; 10/23/13 at 3:26 p.m. during which the resident was not observed to participate in any organized activities or independently engaged in leisure activities. R110 had been admitted to the facility on 9/21/13, with diagnosis that included acute mental status changes secondary to acute bilateral thromboembolic stroke, chronic kidney disease, and diabetes. R110's admission Minimum Data Set (MDS) dated 9/28/13; identified R110 had severe cognitive impairment with moderately impaired vision, unable to see newspaper headlines but can identify objects. The MDS indicated the following activities were "very important" to R110: participating in favorite activities, and going outside to get fresh air when the weather is good. The MDS indicated the following activities were "Not very important" to R110: being around animal and pets; keeping up with the news; doing things with groups of people; and participating in religious activities. During document review it was revealed R110's activity assessment dated 9/28/13, had not included assessment of individual activity preferences (e.g., favorite activity, past preferences, hobbies.) Review of R110's activities care plan (CP) dated 10/11/13, included intervention to "Provide a weekly activity calendar and explanation of programs content and locations" and "Provide resident opportunities for	F 248	carried out per their activity preference assessment for one month, then monthly for three months. 5. The Correction will be Monitored by: A. DON or designee. B. DON or designee will report audit findings to the QA Committee.	12-3-13

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F 248	Continued From page 2 leisure interests such as looking at magazines, watching TV, movies, and music to provide a diversion when resident is otherwise unoccupied." During interview on 10/24/13, at 10:16 a.m. the recreation director (RD) verified she had not completed a comprehensive activities assessment for R110. The RD stated, " I had a hard time getting her to talk to me." RD reported R110 had been invited to group activities however had refused to attend. The RD reported follow-up visits had been completed however was unable to produce documentation to reflect these visits. A request was made for a copy of the facilities activity program however it was not provided.	F 248		
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 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	F 279	F279 1. Corrective Action: A. Resident's (R62) care plan changed to include monitoring for potential side effects of Coumadin usage. B. Resident's (R51) care plan updated to include diagnosis of seizure disorder and also monitoring for potential side effects of Tegretol usage. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for developing a comprehensive care plan was reviewed with the nurse managers on 11/14/13.	

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F 279	Continued From page 3 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 plan of care that included monitoring for side effects of an anti-coagulant medication (Coumadin) for 1 of 5 residents (R62) and in addition failed to develop a care plan for tegretol (anti- convulsant) for 1 of 5 residents (R51) reviewed for unnecessary medications. Findings include: R62 current comprehensive care plan had not addressed risk factors and interventions for excessive bleeding or bruising associated with the use of Coumadin in order to alert care givers the need to report bruising and bleeding timely to the nurse. R62's diagnoses included atrial fibrillation and were being treated with Coumadin therapy to reduce the chance of developing blood clots. The current physician orders dated 10/1/13, identified R62 received Coumadin 2 milligrams (mg) daily. Review of R62's lab reports from 7/22/13 to 10/18/13, identified the ProTime test (used to determine the clotting tendency of blood. If the number is too high it could cause excessive bleeding and the resident will bruise easily) to determine a therapeutic range. It was noted that the ProTime reading was towards the high range which would result in the resident ' s clotting ability to take longer. Review of R62's medical record revealed multiple occasions where	F 279	B. All care plans will be reviewed to assure potential side effects of medications and key diagnoses are included. 3. Date of Completion: 12/3/2013. 4. Reoccurrence will be Prevented by: A. DON or designee will complete chart audits weekly to assure care plans are complete for one month, then monthly for three months. 5. The Correction will be Monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 279	Continued From page 4 bruising had been identified by staff. During interview on 10/24/13 at 9:51 a.m. the director of nursing (DON) verified R62's current care plan lacked risks, goals or interventions related to the Coumadin therapy and high risk of bleeding and bruising. The DON stated, "The risk of bruising and bleeding with Coumadin should always be included in the care plan." R51 received routine medication for seizure control however, R51 ' s comprehensive care plan did not address the signs and symptoms of seizures nor possible adverse anti-seizure medication side effects to alert care givers of the need to immediately report these signs and symptoms to the nurse. Also on how to protect the resident if they have a seizure. R51 was admitted on 7/23/13 with diagnoses that included but not limited to seizure disorder which was treated with an anti-seizure medication Tegretol. The current physician orders dated 8/22/13, read R51 received carbamazepine (Tegretol) 300 milligrams one tablet two times a day for anti-convulsant. R51's care plan dated 8/26/13, revealed there had not been interventions to address R51 ' s seizure disorder nor signs and symptoms of Tegretol adverse side effects. During interview on 10/23/13, at 6:10 p.m., registered nurse (RN)-A stated the seizure disorder should be care planned and verified R51's care plan had not addressed the seizure disorder and routine medication usage. During interview on 10/23/13, at 6:34 p.m., the director of nursing stated they would have	F 279		

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F 279	Continued From page 5 expected the seizure disorder to have been care planned with interventions so staff was aware of what to do. Document review of the facility Care Planning IDT (interdisciplinary team) dated revised 5/11, read " Policy: The care planning process begins during pre-admission/intake and continues on a regular basis throughout the resident/patient stay. The resident and/or their representative, along with the entire care team are involved in the care planning process. Care is planned to help attain or maintain the resident ' s/patient ' s highest practicable physical, mental and psychosocial wellbeing. Purpose: To assure continuity of care at admission; to assure residents ' needs can be met at admission; and to provide a system for an ongoing process of developing and updating a comprehensive care plan with input from the resident, family, representative, and an interdisciplinary team (IDT). Procedure: III. Comprehensive Assessment and Care Plan d. The comprehensive care plan at a minimum includes a problem/need statement, long and short term goals with timetables, interventions, and which discipline is responsible to implement the interventions. It is acceptable to refer to interventions on a permanent Kardex or initial care plan; however, goals are added once the comprehensive assessment is completed. Strengths and preferences of the resident are considered in the interventions. Goals are set with the following outcomes in mind: Improvement is expected - Rehabilitation goals; Prevention - Prevent decline in functioning to the degree possible; address risk factors; Maintenance - Maintain the resident's current ability as long as possible; Palliative - Keep the resident as comfortable as possible. VII. The	F 279		

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F 279	Continued From page 6 comprehensive care plan is used by all personnel involved in the care of the resident."	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive resident ' s care plan was followed for personal hygiene for 3 of 3 residents (R54, R3, R68) reviewed for personal hygiene; failed ensure the written care plan was followed for 1 of 3 residents (R51) reviewed for accidents; failed to ensure the written care plan was followed for 1 of 3 residents (R18) reviewed for pressure ulcers. Finding Include: R54 was observed to have facial hair and had been assessed to need extensive assist of one staff for personal hygiene needs as written in their comprehensive care plan. Review of the care plan dated 10/8/13, revealed R54 required extensive assist of one staff with personal hygiene care needs. During an observation on 10/21/13 at 10:41 a.m., R54 was observed to have long chin hairs around her chin and mouth. On 10/22/13 at 8:34 a.m.,	F 282	F282 1. Corrective Action: A. The DON and Charge Nurse talked to and educated the staff regarding the need to follow the care plan for Residents (R54, R3, R68, R51, and R18). B. Resident (R51) was immediately assisted by staff on 10/23/13 at the time of discovery. Fall prevention interventions were put into place per the care plan. C. Resident (R18) has been reassessed to include risk factors for pressure ulcers and tissue tolerance over pressure points both lying and sitting. 2. Corrective Action as it applies to Other Residents: A. Will review need to follow care plans for all residents at all staff meeting on 11/26/13. B. CNAs will be educated on 11/26/13 to monitor for unwanted facial hair and to remove the unwanted facial hair upon discovery. C. The policy and procedure for tissue tolerance testing, and the forms for tissue tolerance	

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F 282	Continued From page 7 R54 was observed to have long chin hairs around her chin and mouth. Again on 10/23/12 at 1:11 p.m., R54 was observed to have long chin hairs around her chin and mouth. R3 was observed to have facial hair even though they had been assessed to need total assistance for personal hygiene as written in their comprehensive care plan. Review of the care plan dated 2/6/02, revealed R3 required total dependence on staff with her personal hygiene care. During an observation on 10/21/13 at 3:00 p.m., R3 was observed to have long chin on her chin. On 10/22/13 at 8:43 a.m., R3 was observed to have long chin hair on her chin. Again on 10/23/12 at 1:15 p.m., R3 was observed to have long chin hair on her chin. R68 was observed to have facial hair and had been assessed to need extensive assist of one staff for personal hygiene as written in their comprehensive care plan. Review of the care plan dated 6/20/12, revealed R68 required assist of one staff and supervision with her personal hygiene care. During an observation on 10/21/13 at 2:56 p.m., R68 was observed to have several short chin hairs. On 10/22/13 at 8:38 a.m., R68 was observed to have several short chin hairs. Again on 10/23/12 at 1:17 p.m., R68 was observed to have several short chin hairs. During interview on 10/23/13, at 1:46 p.m., nursing assistant (NA)-A indicated that facial hair	F 282	testing and skin risk assessment have been reviewed with the nurse managers on 11/14/13. D. CNAs will be educated on 11/26/13 to assure correct times are written down on toileting and repositioning sheets. E. All other residents will be reassessed, if needed. 3. Date of Completion: 12/3/2013. 4. Reoccurrence will be Prevented by: A. DON or designee will audit for unwanted facial hair weekly for one month, then monthly for three months. B. DON or designee will audit to assure care planned safety interventions are being followed weekly for one month, then monthly for three months. C. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. 5. The Correction will be Monitored by: A. DON or designee.	

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F 282	Continued From page 8 removal was to be completed with morning cares. NA-A verified R54, R3 and R68's morning cares were completed and verified shaving had not been completed for R54, R3 or R68 today. NA-A verified R54 had long chin hairs around her chin and mouth, R3 had long chin hair on her chin and R68 several short chin hairs. During an interview on 10/23/13 at 2:08 p.m., the director of nursing (DON) stated she expected the nursing assistant to see if residents needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, I would expect the staff member to complete the task. The DON verified removal of facial hair for residents was a standard of care. The DON verified R54 had long chin hairs around her chin and mouth, R3 had long chin hair on her chin and R68 several short chin hairs. The DON verified the plan of care for assist with personal hygiene had not been followed for R54, R3 and R68. R51's fall interventions had not been implemented according to their comprehensive plan of care. On 10/23/13, at 2:13 p.m., R51 was observed to be sitting on the edge of recliner chair leaning forward and attempting to stand up with feet sliding on the floor. R51 had no shoes on and had regular socks and not gripper socks on both feet. R51 had no alarm in place in the recliner. Surveyor intervened by immediately notifying staff of R51 ' s current condition. R51's care plan dated 8/26/13 indicated R51 was a fall risk, had history of falls and impulsive behavior. Diagnoses included history altered mental status, Lewy body dementia, Parkinson ' s	F 282	B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 282	Continued From page 9 disease, anxiety, depression, psychosis and glaucoma. Fall interventions (not all inclusive) initiated on 8/26/13 indicated personal safety alarm (PSA) to chair. Document review of facility message sent to all staff on 9/18/13, subject of R51's safety, reminded staff that gripper socks to be worn at all times for falls safety. During interview on 10/23/13, at 2:14 p.m., nursing assistant (NA)-G verified R51 had regular socks on feet not gripper socks and had no alarm in place on recliner. CN-A verified gripper socks on at all times and PSA alarm on chair was current fall interventions on R51's care plan. During interview on 10/23/13, at 2:33 p.m., licensed practical nurse (LPN)-B verified gripper socks on at all times and PSA alarm on chair were current fall interventions on R51's care plan. LPN-B stated evening shift starts at 2:00 p.m. and nursing assistants are to make rounds at the end of their shift to assure things are in place before going off shift. During interview on 10/23/13, at 2:41 p.m., director of nursing stated she expected staff to follow R51's care plan and have interventions in place. Document review of the facility Care Planning IDT (interdisciplinary team) dated revised 5/11, read " To assure continuity of care at admission; to assure residents ' needs can be met at admission; and to provide a system for an ongoing process of developing and updating a comprehensive care plan with input from the resident, family, representative, and an interdisciplinary team (IDT). Procedure: VII. The comprehensive care plan is used by all personnel	F 282		

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F 282	Continued From page 10 involved in the care of the resident." R18 had had not been assisted with repositioning every two hours according to the plan of care and went two hours and twenty minutes before being repositioned. R18 was assessed to be at risk to develop skin breakdown. R18 had diagnoses that included but not limited to, left distal radius fracture, chronic renal failure stage two, pre-diabetes, peripheral edema, depression and cognitive decline. During continuous observation on 10/24/13, R18 had been observed sitting in a wheelchair from 1:08 p.m. to 3:28 p.m. (a total of two hours and twenty minutes) without staff assistance in repositioning. R18's initial care plan dated 9/27/13, identified potential for skin breakdown, turn and reposition every two hours and as needed, impaired physical mobility, required physical assist of one or two staff for transfers, ambulation, bed mobility, and physical assist with wheelchair mobility. During interview on 10/22/13, at 3:28 p.m., nursing assistant (NA)-H stated R18 was to be repositioned every two hours. NA-H showed surveyor a toileting and repositioning report sheet that had a time of 1:20 p.m. as the last time R18 had been last repositioned. NA-H stated the evening shift had started at 2:00 p.m. Surveyor informed NA-H R18 had not been repositioned since 1:08 p.m. During interview on 10/22/13, at 3:45 p.m., director of nursing stated she would expect	F 282		

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F 282	Continued From page 11 nursing assistants to write accurate times for repositioning. Document review of the facility Care Planning IDT (interdisciplinary team) dated revised 5/11, read "To assure continuity of care at admission; to assure residents ' needs can be met at admission; and to provide a system for an ongoing process of developing and updating a comprehensive care plan with input from the resident, family, representative, and an interdisciplinary team (IDT). Procedure: VII. The comprehensive care plan is used by all personnel involved in the care of the resident."	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative nursing services for ambulation were consistently provided for 1 of 1 resident (R30) reviewed for ambulation. Findings include: R30 had not been ambulated twice daily (BID) for a minimum of 50 feet due to staff not having time to complete this nursing rehabilitative task for residents. R30's diagnoses included difficulty walking and	F 311	F311 1. Corrective Action: A. DON talked to staff regarding the need to follow restorative nursing care plan. 2. Corrective Action as it applies to Other Residents: A. Reviewed need to follow care plans for all residents at all staff meeting on 11/26/13. 3. Date of Completion: 12/3/2013. 4. Reoccurrence will be Prevented by: A. DON or designee will randomly, but at least weekly audit restorative	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 depression. The annual Minimum Data Set (MDS) dated 8/31/13, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R30 had moderate cognitive impairment. The MDS further revealed R30 required extensive assist of one staff for transferring, walking in corridor, toileting and locomotion. The prior quarterly MDS dated 6/18/13, indicated R30 required limited assistance with ambulation in room. R30 went from limited assistance in 6/13 to extensive assistance 8/31. During review of R30 ' s restorative nursing program care plan dated 1/7/07 it read that the goal had been to maintain ability to ambulate 50 feet with wheeled walker and assist of one staff and wheelchair to follow. Interventions directed staff to ambulate with wheeled walker and staff assist of one with wheelchair to follow, ambulate 50 feet twice a day. R30 ' s ambulation program located on the computer which was for nursing assistant reference read the resident twill maintain ability to ambulate 50 feet with wheeled walker and one staff assist wheelchair to follow. Ambulate twice a day 6-7 days per week. During observation on 10/24/13 at 9:48 a.m. nursing assistant (NA)-F went to R30's room and offered to walk resident. R30 confirmed they would like to go for a walk. NA-F grabbed the wheeled walker and placed it in the hallway. NA-F then asked licensed practical nurse (LPN)-A to help push the wheelchair behind R30 while resident walked. NA-F put the transfer belt on R30 and assisted them to a standing position. R30 had been observed to walk without difficulty.	F 311	nursing ambulation logs to assure restorative care plans are being followed for one month, then monthly for three months. 5. The Correction will be Monitored by: A. DON or designee. B. The DON will summarize the care observation results and present the information to the QA Committee on a quarterly basis for further direction.	12-3-13

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F 311	Continued From page 13 NA-F indicated R30 walked 75 feet today. NA-F verified R30 was to be walked twice a day but due to short staffing there was not always time to get the walks done for R30. During review of ambulation detail report for the month of October 2013, identified R30 was walked 20 times out of a total of 62 opportunities and walked from 25 feet to 230 feet. · 10/1 walked 3 minutes for 50 feet · 10/2 walked 5 minutes for 60 feet · 10/3 walked 2 minutes for 30 feet · 10/4 walked 5 minutes for 30 feet · 10/5 walked 4 minutes for 50 feet · 10/6 walked 6 minutes for 100 feet · 10/7 walked 5 minutes for 50 feet · 10/8 walked 12 minutes for 50 feet · 10/9 walked 8 minutes for 80 feet · 10/10 walked 11 minutes for 230 feet · 10/11 walked 4 minutes no feet documented · 10/12 walked 5 minutes for 30 feet · 10/13 walked 5 minutes for 30 feet · 10/14 walked 17 minutes for 50 feet · 10/15 walked 4 minutes for 50 feet · 10/16 walked 3 minutes for 50 feet · 10/17 walked 2 minutes for 25 feet · 10/18 no documentation · 10/19 refused x 1 not offered any more · 10/20 walked 4 minutes for 60 feet · 10/21 walked 3 minutes for 100 feet · 10/22 walked 4 minutes for 50 feet During interview on 10/23/13, at 12:04 p.m. R30 indicated they used to walk in the hall but had not walked for a long time in the hall only in the room. R30 said they would like to walk more. During interview on 10/22/13, at 1:45 p.m. NA-B	F 311		

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F 311	Continued From page 14 verified they were " short of staff " and R30 did not get walked because they don ' t have time to get it all done for the residents. NA-B said that there are times they are to document walking as time standing or if the resident is walked in their room from the chair to the bathroom when they don't have time to walk the residents in the hallways like they ' re supposed too. During interview on 10/23/13 at 1:15 p.m. NA-D confirmed they do not have enough time to get all the work done in a timely manner, residents are always waiting. NA-D indicated always tried to get repositioning and toileting done before working on walking residents. During interview on 10/23/13 at 3:33 p.m. NA-E indicated residents may have to wait an extended amount of time to have call lights answered. There are days more chaotic these days the residents may get half a walk or just a " stretch. " During an interview on 10/23/13 at 6:41 p.m., NA-I indicated on the days the facility was short staffed and there were two nursing assistants on the wing for 20 residents the walking or water pass may not get done. NA-I indicated the facility was short staffed because of " call ins " and scheduling. NA-I indicated their wing needed three staff for the whole shift to make sure residents were walked and receive fresh water. During interview on 10/24/13, at 9:48 a.m. NA-F verified R30 was to be walked bid but due to staffing there was not always time to get them done. During interview on 10/23/13, at 6:32 p.m. the director of nursing (DON) indicated if residents are on a twice a day ambulation program she	F 311		

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F 311	Continued From page 15 would expect the resident to be ambulated for 15 minutes a day. DON indicated standing does not count towards the ambulation program. During interview on 10/24/13 at 9:33 a.m. nurse manager-A verified R30 was to be ambulated 50 feet twice a day and it had not been done. During policy review titled Restorative Nursing Program reviewed and revised May 2011, it read that the purpose was to promote each resident's ability to adapt to attain his or her maximum functional potential. Restorative nursing includes but not limited to walking.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident received grooming assistance as necessary related to facial hair removal for 3 of 3 residents (R54, R3 and R68) reviewed for activities of daily living. Finding Include: R54 was dependent on staff assistance for activities of daily living and did not receive the assistance she needed to remove unwanted	F 312	F312 1. Corrective Action: A. The DON and Charge Nurse talked to and educated the staff regarding the need to follow the care plan for Residents (R54, R3, and R68). 2. C corrective Action as it applies to other residents: A. Will review need to follow care plans for all residents at all staff meeting on 11/26/13. B. CNAs will be educated on 11/26/13 to monitor for unwanted facial hair and to remove the unwanted facial hair upon discovery. 3. Date of Completion: 12/3/2013	

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F 312	Continued From page 16 facial hair. Review of the quarterly Minimum Data Set (MDS) dated 10/8/13; revealed R54 had severe cognitive impairment and required extensive assist of one staff for personal hygiene. Review of the care plan dated 10/8/13, revealed R54 required extensive assist of one staff with her personal hygiene care. During an observation on 10/21/13 at 10:41 a.m., R54 was observed to have long chin hairs around her chin and mouth. On 10/22/13 at 8:34 a.m., R54 was observed to have long chin hairs around her chin and mouth. Again on 10/23/12 at 1:11 p.m., R54 was observed to have long chin hairs around her chin and mouth. R3 was dependent on staff assistance for activities of daily living and did not receive the assistance she needed to remove facial hair. Review of the quarterly Minimum Data Set (MDS) dated 9/19/13; revealed R3 had severely impaired decision making skills for daily living and required total dependence on staff for personal hygiene. Review of the care plan dated 2/6/02, revealed R3 required total dependence on staff with her personal hygiene care. During an observation on 10/21/13 at 3:00 p.m., R3 was observed to have long chin on her chin. On 10/22/13 at 8:43 a.m., R3 was observed to have long chin hair on her chin. Again on 10/23/12 at 1:15 p.m., R3 was observed to have long chin hair on her chin.	F 312	4. Reoccurrence will be prevented by: A. DON or designee will audit for unwanted facial hair weekly for one month, then monthly for three months. B. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed. 5. The correction will be monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 312	Continued From page 17 R68 was dependent on staff assistance for activities of daily living and did not receive the assistance she needed to remove facial hair. Review of the quarterly Minimum Data Set (MDS) dated 8/26/13; revealed R68 had moderately impaired decision making skills for daily living and required extensive assist of one staff for personal hygiene. Review of the care plan dated 6/20/12, revealed R68 required assist of one staff and supervision with her personal hygiene care. During an observation on 10/21/13 at 2:56 p.m., R68 was observed to have several short chin hairs. On 10/22/13 at 8:38 a.m., R68 was observed to have several short chin hairs. Again on 10/23/12 at 1:17 p.m., R68 was observed to have several short chin hairs. During interview on 10/23/13, at 1:46 p.m., nursing assistant (NA)-A indicated that facial hair removal was to be completed with morning cares. NA-A verified R54, R3 and R68's morning cares had been completed and verified shaving of the facial hair had not been completed for R54, R3 or R68 today. During an interview on 10/23/13 at 2:08 p.m., the director of nursing (DON) stated she expected the nursing assistant to see if residents needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, she would expect the staff member to complete the task. The DON verified removal of facial hair for residents was a standard of care. Review of the Nursing Care Standard dated May	F 312		

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F 312	Continued From page 18 2011, read, " To ensure that every resident receives care to reach their highest practicable level of function, the standards listed below should be followed." The standards included, " Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a skin reassessment after developing a stage III pressure ulcer and provide repositioning services to promote healing and prevent further ulcers from developing for 1 of 3 residents (R18) reviewed for pressure ulcers. Findings include: R18 had been admitted on 9/27/13 and had developed a stage 3 pressure ulcer after admission to the facility and first noted on 10/7/13. Also R18 had not been repositioned for 2 hours and twenty minutes even though R18 had	F 314	F314 1. Corrective Action: A. Resident's (R18) skin was reassessed per policy and procedure. B. DON spoke with Nurse Manager and educated her on the importance of reassessing and documenting all new skin concerns. 2. Corrective Action as it applies to all other Residents: A. The policy and procedure for tissue tolerance testing, and the forms for tissue tolerance testing and skin risk assessment have been reviewed with the nurse managers on 11/14/13. B. CNAs will be educated on 11/26/13 to assure correct times are written down on toileting and repositioning sheets. C. All other residents will be reassessed, if needed.	

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F 314	Continued From page 19 been assessed to need repositioning ever two hours. R18 had diagnoses that included but not limited to left distal radius fracture, , chronic renal failure stage two, pre-diabetes, peripheral edema, depression and cognitive decline. The admission Minimum Data Set (MDS) dated 10/4/13, indicated R18 had been at risk for developing pressure ulcer and required one person physical assist with transfers, bed mobility, and wheel chair mobility and one to two person physical assist with ambulation. R18's initial care plan dated 9/27/13, identified potential for skin breakdown, turn and reposition every two hours and as needed, pressure relieving device for chair/bed, skin care per protocol, monitor skin every shift and as needed. Impaired physical mobility related to weakness, left wrist fracture, pleural effusion, SOB (shortness of breath) and required physical assist of one or two staff for transfers, ambulation, bed mobility, physical assist with wheelchair mobility and cast to left arm. Coccyx slit had been written under skin problem of the care plan with no date to identify when it had been added to the care plan. The care plan had a review date of 10/9/13. R18's nurse progress note dated 10/7/13 identified open area of coccyx that measured 2 x 2.5 cm (centimeters.) R18's Braden Scale for predicting pressure sore risk dated 9/27/13 and 10/4/13, both identified friction and shear score of three (no apparent problem, moves in bed and chair independently and has sufficient muscle strength to lift up	F 314	3. Date of Completion: 12/3/2013 4. Reoccurrence will be prevented by: A. The DON or designee will audit charts for documentation and completion of reassessment for all new skin concerns weekly for one month, then monthly for three months. 5. The correction will be monitored by: A. DON or designee. B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed. 12-3-13	

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F 314	Continued From page 20 completely during move), however R18's admission MDS and initial care plan identified R18 as needing physical assist with transfers, bed mobility and wheelchair mobility. No Braden Scale had been completed after the development of open area on coccyx on 10/7/13 (dates of 10/11 and 10/18 had been written on the sheet with no information filled in.) Document review of R18's skin assessment dated 10/3/13, identified tissue tolerance (to determine how long pressure on bony prominence's may result in skin breakdown) deferred, cushion in w/c, being assisted with frequent repositioning. Again there had not been a skin assessment completed after the development of open area on coccyx on 10/7/13. Document review of skin ulcer data collection and assessment dated 10/15/13, identified pressure ulcer stage three measuring 0.7 cm x 1.3 cm, full thickness, serous drainage color, minimum drainage amount, 80 percent pink, 20 percent slough, no odor, no pain, care plan complete/up-to-date as yes. Registered nurse analysis/assessment slit on coccyx, treatment provided per facility protocol, being assisted every two hours repositioning, gel cushion in wheelchair, care plan will continue. During continuous observation on 10/24/13, R18 had been observed sitting in a wheelchair from 1:08 p.m. to 3:28 p.m. (a total of two hours and twenty minutes). No repositioning had been done or offered by staff during the continuous observation. During interview on 10/22/13, at 3:28 p.m., nursing assistant (NA)-H stated R18 was to be	F 314		

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F 314	Continued From page 21 repositioned every two hours. NA-H showed surveyor a toileting and repositioning report sheet that had a time of 1:20 p.m. as the last time R18 had been last repositioned. NA-H stated the evening shift had started at 2:00 p.m. Surveyor informed NA-H R18 had not been repositioned since 1:08 p.m. During interview on 10/22/13, at 3:45 p.m., director of nursing stated she would expect nursing assistants to write accurate times for repositioning. During interview on 10/23/13, at 3:13 p.m., registered nurse (RN)-B stated she had written coccyx slit on the initial care plan on 10/15/13 and verified R18 had not had open area on coccyx on admission. RN-B stated no changes had been made in the interventions for R18 related to skin problems since admission, except the treatment to the ulcer area. During interview on 10/24/13, at 8:48 a.m., director of nursing stated she expected staff to complete a skin reassessment for R18 after the development of the pressure ulcer. Document review of the facility Skin Assessment/Braden dated revised 5/11, read " Procedure: The Braden Scale assessment is completed by the Nurse Manager or RN designee: 2. Every week for 4 weeks after admission; 4. In the event of major condition changes." Document review of the facility Skin Assessment and Care dated revised 5/11, read "Policy: Each resident receives the necessary care and services to attain or maintain the highest	F 314		

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F 314	Continued From page 22 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to skin care; a resident who enters the facility pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Purpose: To prevent skin breakdown and provide early intervention and treatment for existing skin problems. Procedure: 2. Within 14 days after admission, a comprehensive skin assessment is completed that addresses at a minimum: b. An evaluation of the skin integrity and tissue tolerance (ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed. i. Pressure reduction or offloading occurs at least every two hours for most residents; however, elderly fragile residents may not be able to tolerate one position for even 2 hours without damage to the underlying tissue. 5. A registered nurse must complete a skin assessment if a new pressure ulcer develops. The assessment must include review of the resident ' s tissue tolerance to pressure."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. Corrective Action: A. The DON and Charge Nurse talked to and educated the staff regarding the need to follow the care plan for Residents (R51)	

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F 323	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were implemented for 1 of 3 residents (R51) reviewed for accidents. Findings include: R51's fall interventions had not been implemented according to the plan of care. On 10/23/13, at 2:13 p.m., R51 was observed to be sitting on the edge of recliner chair leaning forward and attempting to stand up with feet sliding on the floor. R51 had no shoes on and had regular (not gripper or slip reducing) socks on both feet. R51 had no alarm in place while in the recliner. Surveyor immediately informed staff of R51 ' s condition. R51's significant change Minimum Data Set (MDS) dated 9/25/13 identified R51 as being a fall risk with a fall history, had a fracture related to a fall and required extensive assist with transfers. BIMS (Brief Interview Mental Status) cognitive assessment indicated R51 had severe cognitive impairment as evidenced by score 0 of 15. R51's care plan dated 8/26/13 indicated R51 was a fall risk, had history of falls and impulsive behavior. Diagnoses included history altered mental status, Lewy body dementia, Parkinson's disease, anxiety, psychosis, glaucoma. Fall interventions (not all inclusive) initiated on 8/26/13 indicated personal sounding alarm (PSA) to chair.	F 323	B. Resident (R51) was immediately assisted by staff on 10/23/13 at the time of discovery. Fall prevention interventions were put into place per the care plan. 2. Corrective Action as it applies to all other residents: A. Will review need to follow care plans for all residents at all staff meeting on 11/26/13. 3. Date of Completion: 12/3/2013 4. Reoccurrence will be prevented by: A. DON or designee will audit to assure care planned safety interventions are being followed weekly for one month, then monthly for three months. B. DON or designee will randomly, but at least two times a week, observe cares being provided to assure care plans are being followed.	

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F 323	Continued From page 24 Document review of facility message sent to all staff on 9/18/13, subject of R51's safety, reminded staff that gripper socks to be worn at all times for falls safety. R51's fall risk assessment dated 9/19/13, indicated a total score of 75 (score 45 and higher high risk). Fall risk analysis read at high risk for falls, last fall 9/11/13 resulted in a hip fracture, lacks safety awareness and is impulsive. During interview on 10/23/13, at 2:14 p.m., nursing assistant (NA)-G verified R51 had regular socks on feet not gripper socks and had no alarm in place on recliner. CN-A verified gripper socks on at all times and PSA alarms on chair were current fall interventions on R51's care plan. During interview on 10/23/13, at 2:33 p.m., licensed practical nurse (LPN)-B verified gripper socks on at all times and PSA alarm on chair were current fall interventions on R51's care plan. LPN-B stated evening shift starts at 2:00 p.m. and nursing assistants are to make rounds at the end of their shift to assure things are in place for each resident before going off shift. During interview on 10/23/13, at 2:41 p.m., director of nursing stated she expected staff to follow R51's care plan and have interventions in place. Document review of the facility Care Planning IDT (interdisciplinary team) dated revised 5/11, read " To assure continuity of care at admission; to assure residents ' needs can be met at admission; and to provide a system for an ongoing process of developing and updating a comprehensive care plan with input from the	F 323	5. The correction will be monitored by: A. DON or designee B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 323	Continued From page 25 resident, family, representative, and an interdisciplinary team (IDT). Procedure: VII. The comprehensive care plan is used by all personnel involved in the care of the resident."	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently provide nursing staff to meet each resident's assessed needs in a timely manner for 4 of 10 residents (R30, R56, R57, R12) reviewed for having their needs met. This also could affect all 50 residents if staffing	F 353	F353 1. Corrective Action: A. DON reviewed census and acuity levels for entire building. B. Staffing coordinator educated to make sure she replaces staff if there are call ins and to enforce the union mandation policy if staffing levels fall too low. C. Staff members have been educated on the need to answer call lights and tend to residents needs promptly. D. The attendance policy has been reviewed and the staff educated on the need to come to work as scheduled. E. The Administrator and Director of Nursing will contact Ecumen Human Resources and the Union to set a meeting and discuss mandatory overtime requirements related to adequate staffing to meet resident needs.	

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F 353	Continued From page 26 was not sufficient to care for their identified needs as well. Findings include: See F311: Based on observation, interview and document review, the facility failed to ensure restorative nursing services for ambulation were consistently provided for 1 of 1 resident (R30) reviewed for ambulation. R30's diagnoses included difficulty walking and depression. The annual Minimum Data Set (MDS) dated 8/31/13, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R30 had moderate cognitive impairment. The MDS further revealed R30 required extensive assist of one staff for transferring, walking in corridor, toileting and locomotion. During interview on 10/21/13, at 11:08 a.m. R30 indicated when asked if there was enough staff available to make sure you get the care and assistance you need without having to wait a long time. R30 said that nobody answers my call light for half hour to 45 minutes often. R30 further indicated when they need to go to the bathroom they need to go now or they will have an accident (referring to soiling self with urine.) R30 confirmed they had a few " accidents and felt terrible about it. " During interview on 10/23/13, at 12:04 p.m. R30 indicated they used to walk in the hall with staff but had not walked for a long time. R30 indicated they stayed in the wheelchair when going into the bathroom but use to ambulate in the past to the bathroom. R30 identified they had weakness of	F 353	2. Corrective Action as it applies to other residents: A. Will review the need to follow care plans at all staff meeting on 11/26/13. B. DON and Nurse Managers will monitor the facility's census and acuity levels on a daily basis to ensure appropriate staffing levels. C. St. Mark's Administrator, DON and Human Resources will conduct a meeting with Ecumen Human Resources to discuss recruiting and retention of staff in addition to the attendance policy. 3. Date of Completion: 12/3/2013 4. Reoccurrence will be prevented by: A. DON and nurse managers will monitor census, acuity and staffing needs on a daily basis. B. Social Worker will communicate with Residents and their families for concerns with staffing levels.	

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F 353	Continued From page 27 the left side of lower extremities and needed staff help to walk. R30 said it had been a while since they had a good walk. R30 said they would like to walk more. R56's diagnoses included diabetes and anemia. The quarterly MDS dated 8/14/13, revealed a BIMS score of 15 out of 15, which indicated R56 had no cognitive impairment. The MDS further revealed R56 required extensive assistance with one staff with transfers and toileting. During interview on 10/21/13, at 1:44 p.m. R56 indicated when asked if there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R56 said, " NO! " R56 indicated sometimes they had to wait 10-15 minutes to go to the bathroom and it did not depend on any particular time of the day. R57's diagnoses included diabetes and congestive heart failure. The significant status change MDS dated 8/19/13, revealed a BIMS score of 1 out of 15. R57 cognition fluctuated but was able to answer the qualifying interview questions prior to stage I interview. The MDS further revealed R57 required extensive assistance with two staff with transfers and toileting. During interview on 10/21/13, at 1:44 p.m. R57 indicated when asked if there was enough staff available to make sure you get the care and assistance you need without having to wait a long time. R57 said, " No. " R57 indicated had to wait up to 30 minutes to have their call light answered when they needed help right away.	F 353	C. Director of Nursing will conduct weekly audits related to call lights, ambulation and staff attendance for one month and then monthly audits for three months. 5. The correction will be monitored by: C. DON or designee D. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 353	Continued From page 28 R12's diagnoses included congestive heart failure and hypertension. The quarterly MDS dated 8/29/13, revealed a BIMS score of 15 out of 15, which indicated R12 had no cognitive impairment. The MDS further revealed R56 required extensive assistance with two staff with transfers and toileting. During interview on 10/21/13, at 1:14 p.m. R12 indicated when asked if there was enough staff available to make sure you get the care and assistance you need without having to wait a long time. R12 said, " No. " R12 could not walk alone and had been left on the commode for 15-30 minutes before staff would come back and take me off the commode or had to wait 15-30 minutes to get help to the commode. During interview on 10/22/13, at 1:14 p.m. nursing assistant (NA)-A indicated some residents had said they were incontinent because they had to wait so long for help. Yesterday a resident needed to go to the bathroom and was upset because someone answered the call light and shut off the call light and had not let the nursing assistant responsible for residents care know the resident's needs. NA-A said another resident had their call light on for 45 minutes when a staff member came in the resident ' s room then they turned off the call light and told the resident they would be right back, but didn ' t return. NA-A revealed staff frequently have answered residents shut call lights then turn them off and never come back to help the resident as they are not on their work group. They don ' t tell the aide who is assigned to this resident either. During interview on 10/22/13, at 1:45 p.m. NA-B	F 353		

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F 353	Continued From page 29 verified they are short of staff and if there are three strong aides on this wing then the work can get done except waling of the residents as they don ' t have time. NA-B also said that document time the resident may be standing or walked in room from chair to the bathroom as the same as being walked in the hallway. NA-B indicated they frequently had residents upset with the time they have had to wait for call lights to get answered. Administration keeps telling us there is plenty of staff working but there really isn't. The nurse manager usually hides in her office when here except when you surveyors are in the building then she helps with resident cares. During interview on 10/23/13, at 1:08 p.m. NA-C indicated they worked various shifts and many times works a double. NA-C said that staffing on weekends in general was not good. NA-C said on the weekends they routinely scheduled with one less staff on the floor. The licensed nurses are supposed to help but not all of them do. NA-C indicated some of the nurses will answer fall alarms that are sounding and some will not. NA-C verified they do not always have time to walk the residents, or they may just walk the resident in their room or pass it on to the next shift that the walks were not done as they don ' t have time to get it done. During interview on 10/23/13 at 1:15 p.m. NA-D confirmed they do not have enough time to get all the work done for each resident in a timely manner, residents are always waiting. NA-D indicated they always tried to get repositioning and toileting done before working on walking residents. NA-D said residents have had to wait a long time to get call lights answered. NA-D verified they had residents say they were	F 353		

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F 353	Continued From page 30 incontinent because they had to wait to long for help. NA-D indicated R30 told them that it felt like there was no one here one morning to help them to the toilet and they were incontinent while waiting. The nurse managers do not come out of their offices to help with resident cares unless you surveyors are here. NA-D indicated about 50-60% of the time there are only two staff working the shift and if full staff would have three nursing assistants. NA-D said that this past weekend there were a lot of staffing issues and the nurse manager were here all weekend but they did not come out of the office and help with resident cares at all. At 2:00 p.m. the nurse manager came out of the office and asked staff to stay into the next shift due to call INS but never offered to help. Administration wants us to go to the lean program to work more with less help. NA-D indicated this morning residents were lying in wet pads and dried bowel, this was reported to the nurses but nothing seems to be done about it. During interview on 10/23/13 at 1:38 p.m. licensed practical nurse (LPN)-A indicated they also don't feel there had been enough staff. LPN-A verified on an occasion residents were not happy about the time they had to wait for call lights to be answered but explain that the staff will be there as soon as they can. LPN-A said they are busy too and don't have time to answer call lights and assist with resident cares. During interview on 10/23/13 at 3:33 p.m. NA-E indicated residents may have to wait an extended amount of time to have call lights answered. There are days when it is more chaotic and on these days the residents may get half a walk or just a " stretch. "	F 353		

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F 353	Continued From page 31 During an interview on 10/23/13 at 6:41 p.m., NA-I indicated on the days the facility was short staffed and there were only two nursing assistants on the wing for 20 residents the walking or water pass may not get done. NA-I indicated the facility was short staffed because of " call ins " and scheduling. NA-I indicated the wing (20 residents) needed three staff for the whole shift to make sure the residents was walked and that they receive fresh water. During interview on 10/24/13 at 9:33 a.m. nurse manager-A indicated there was enough staff available on the floor to meet resident needs. Nurse manager-A indicated they had not been aware of residents having to wait for call lights to be answered timely. Nurse manager-A verified R30 was to be ambulated 50 feet twice a day and this had not been done. During interview on 10/24/13, at 9:48 a.m. NA-F put walker in front of R30 and LPN-A walked behind resident walked 75 ft. NA-F verified R30 was to be walked bid but due to staffing there is not always time to get them done. During interview on 10/23/13, at 6:32 p.m. the director of nursing (DON) indicated when staff would call in they were to give at least a two hour notice they will not be at work but she do not require another staff to fill this position. The DON indicated they have authority to mandate with the union to have the staff stay for a second shift but the staff can choose to take an absence instead of staying. The DON indicated if residents are on a twice a day ambulation program she would expect the resident to be ambulated for 15 minutes a day. The DON would expect the call lights to be answered timely to prevent incontinence. DON indicated it is " sad " if	F 353		

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F 353	Continued From page 32 residents were incontinent due to staff not answering call light During interview on 10/24/13, at 10:51 a.m. the DON indicated call lights were audited on each shift once each month by going into a room and put the call light on and waits for staff to answer the light. DON indicated don ' t have time to how much time it takes for staff to answer call lights put on by the resident.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F356 1. Corrective Action: A. DON spoke with Staffing Coordinator and Nurse Managers and educated them on the process for posting staffing hours. B. Updated staffing hours was posted. 2. Corrective Action as it applies to other residents: A. All Staff will be educated on the process of posting staffing hours at the all staff in service on 11/26/2013. 3. Date of Completion: 12/3/2013 4. Reoccurrence will be prevented by: A. The DON or designee will complete weekly audits to assure staffing hours are posted at the beginning of each day and checked for accuracy for one month,	

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F 356	Continued From page 33 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to post the required information for nursing hours on a daily basis at the beginning of each shift. This had the potential to affect all 50 residents living in the facility. Findings include: During initial tour observation on 10/21/13, at 8:50 a.m. noted daily staff posting of hours was dated 10/18/13 which was last Friday. During interview on 10/21/13, at 8:50 a.m. nurse manager-B verified the posting was dated for 10/18/13 and indicated it was the responsibility of the nurse manager on the weekend to change the posting to the current date. During interview on 10/23/13, at 6:33 p.m. the director of nursing indicated the scheduler makes up the daily staff posting for the weekend on Friday and the nurse manager needs to make sure the correct date was posted over the weekend. The director of nursing verified the date on the daily posting of hours on 10/21/13 was dated 10/18/13 last Friday. Reviewed policy dated November 2011, titled staff posting requirements read that a daily nursing hour's form had been implemented and should be posted every day.	F 356	then monthly for three months. 6. The correction will be monitored by: A. DON or designee B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 371 F 371 SS=F	Continued From page 34 483.35(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 containers were dated and labeled when opened and failed to ensure food containers were sealed when storing food. This had the potential to affect 50 out of 50 residents in the facility who eat the foods prepared by the facility kitchen. Findings include: The facility had not dated 25 opened food containers, had not labeled 12 opened food containers and had not assured 13 opened food containers had been sealed properly. During the initial tour of the main kitchen on 10/21/13, at 8:52 a.m., with dietary cook (C)-A the following was observed: A refrigerator had seven separate dishes of bread pudding on a cookie sheet covered by another cookie sheet laid over the top with a gap between the cookie sheets undated, unlabeled and not sealed. The bread pudding was left over from the	F 371 F 371	F371 1. Corrective Action: A. The Dietary Director spoke with staff about proper storage and handling of food. B. All opened and undated/unlabeled food items were disposed of. 2. Corrective Actions as it applies to other residents: A. All dietary staff will be re-educated about proper storage and handling of food at their department meeting on 12/2/2013. B. All staff will be educated about proper storage and handling of food at the all staff meeting on 11/26/2013. 3. Date of Completion: 12/3/2013. 4. Reoccurrence will be prevented by: A. The DON and dietary director have created food storage and handling audit. B. The DON, dietary director, or designee will conduct	

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F 371	Continued From page 35 evening before. The walk in cooler had one big mixing bowl of prunes, four single dishes of prunes on a tray and seven and one half pieces of bread pudding on a tray unlabeled and undated. C-A was unsure when the prunes were put in the bowl or dishes. The walk in freezer had one opened bag of chicken breast chunks undated as to when it was opened, one opened bag of chicken breasts also undated when opened, two opened bags of potato wedges undated and not fully sealed, one open bag of peas undated, one open bag of carrots undated, one opened bag of breaded chicken breasts undated, one opened package of bacon undated. During interview on 10/21/13, at 9:03 a.m., C-A stated she did not know when the prunes had been opened and did not know why the foods had not been dated, labeled and fully sealed. During interview on 10/23/13, at 12:50 p.m., dietary director stated she expected staff to date, label and sealed properly. Review of the facility Leftover Food Usage dated 11/3/11, read "Procedures 5. Store leftover foods in containers with tight-fitting lids. 6. Label all containers clearly with the date and what the item is. " Review of the facility Food Preparation and Handling dated 11/3/11, read "Procedure 3. Potentially hazardous food is kept refrigerated or frozen, except during handling. a. Food is covered, labeled, labeled for storage. 30. Leftovers are dated, labeled, covered, cooled, and stored (within 30 minutes after cooking or service) in a refrigerator."	F 371	random audits weekly for one month, then monthly for three months to assure compliance. 5. The correction will be monitored by: A. DON or designee B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

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F 441	Continued From page 36	F 441		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 1. Corrective Action: A. Nurse Managers instructed to start monitoring infections on the infection control log for the residents that they are responsible. B. The DON has initiated the tracking and trending analysis of infections in the facility. 2. Corrective Action as it applies to other residents: A. DON will obtain training on how to monitor infection control. B. The Staffing Coordinator will track staff call ins due to illness and give the information to the DON weekly for tracking and trending. C. The IDT team will discuss new infections and trends related to infections briefly each morning and more in depth at the weekly risk management meeting. 3. Date of Completion: 12/3/2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/24/2013

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) COMPLETION DATE
F 441	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program to include surveillance and investigation of infections that occur in the facility, track employee infections, and maintain accurate and comprehensive records of infections. This had the potential to affect all 50 residents residing in the facility, employees and visitors. Findings include: Requested the facility for the Monthly infection Log(s) from March 2013, through October 2013, they were received and there were none found for the months of April, May, June, and October 2013. For the months of July, August and September 2013, the following had not been included on the Resident Monthly Infections Log(s): Organism of infection, signs and symptoms of infection, date of onset of the symptoms, culture results, or whether the infection was community or facility acquired. The logs provided also lacked consistent indication of the body system (lungs, bladder, etc.) involved in the infection. During review of monthly infection log from September 2013 room #s and resident name was completed. Date of onset of the infection, signs and symptoms, culture results were not completed for five urinary tract infections and had no culture results noted. Three out of five urinary tract infections had more than one antibiotic ordered or antibiotic extended during that infection period. For the month of August 2013, six urinary tract infections were treated with no culture results documented, date of onset,	F 441	4. Reoccurrence will be prevented by: A. Thorough education to the infection control policy for all staff. B. The DON will monitor tracking of infections by the Nurse Managers and Staffing Coordinator weekly for one month, then monthly for three months. 5. The correction will be monitored by: A. DON or designee B. The QA Committee will review the audit results on a quarterly basis and provide further direction, as needed.	12-3-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/24/2013

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) COMPLETION DATE
F 441	Continued From page 38 signs and symptoms. One resident was listed on monthly infection log with no site of infection but treated with antibiotic. In July 2013, three urinary tract infections with no culture results, date of onset of the infection nor signs and symptoms were documented. On asking for tracking and trending employee illnesses none was provided by the facility. During interview on 10/22/13, at 10:03 a.m. the director of nursing (DON) indicated she took over the infection control tracking and trending since July 2013. The DON indicated there was not a lot of time to focus on infection control program. DON indicated she was currently working on the logs to prepare for quality assurance meeting. During interview on 10/23/13, at 6:23 p.m. the DON verified the paper tracking and trending was not quite up to date. The monthly infection logs are to be completed quarterly. The DON revealed there had not been time to accurately complete what needed to be done for monitoring infection control. Policy dated 11/09, titled infection control and prevention program read that the facility was to develop, implement and maintain infection prevention and control program in order to prevent, recognize and control to the extent possible, the onset and spread of infection within the facility. However, the policy review dated May 2011, titled Employee Health Infection control had not addressed tracking and trending of staff illness and had not been a part of the overall infection control program.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/24/2013

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) COMPLETION DATE

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 _____	**10/23/2013**

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) COMPLETION DATE
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	POCok TB 11-29-13 RECEIVED NOV 22 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DOC 10-3-13
EXIT: 10-24-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Sahlgren	Administrator	11/16/13

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.

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 _____	**10/23/2013**

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) COMPLETION DATE
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. This facility will be surveyed as two separate buildings. 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		

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 _____	10/23/2013

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) COMPLETION DATE
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 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 25 out of 52 residents. Findings include: On facility tour between 8:30 AM and 12:30 PM on 10/23/2013, observation revealed that the following was found:	K 029	K29 First floor Activity/Mechanical room: The door now has a 1 inch hole repaired and covered with a metal plate. First floor Storage/Mechanical room: Open penetrations on the north wall have been cemented and fire caulked. First floor Mechanical room: Open penetrations on the south and west walls have been cemented and fire caulked. Basement-North Break room storage room: Open penetrations on the west wall have been cemented and fire caulked. All of the above was completed as of 11/12/2013.	

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 _____	**10/23/2013**

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) COMPLETION DATE
K 029	Continued From page 3 1. 1st floor - Activity storage room (over 50 sq ft) has a 1 inch hole in door 2. 1st floor - Storage / Mechanical room - open penetration on north wall 3. 1st floor - North mechanical room, open penetrations on south and west walls 4. Basement - North break room storage room (over 50 sq ft) has open penetration on west wall These deficient practices were confirmed by the Director of Environmental Services (BR) at the time of discovery.	K 029		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 - 2-3.5.1. Findings include:	K 052	K52 First floor Memory Care areas: The two smoke detectors (3-38 and 3-47) have been moved so they are more than three from the return vents. This was completed as of 11/4/2013.	

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 _____	**10/23/2013**

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) COMPLETION DATE
K 052	Continued From page 4 On facility tour between 8:30 AM and 12:30 PM on 10/23/2013, observation revealed that smoke detectors 3-38 and 3-47 are located with-in 3 feet of the air flow of the return vents on 1st floor - memory care unit. This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery.	K 052		
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by:	K 071	K71 First floor main hallway laundry chute: One of the two sprinkler heads that was in the laundry chute has been removed as of 10/25/2013.	

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 _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 071	Continued From page 5 Based on observations and staff interview, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and 1999 NFPA 82 Section 3-2.5.. This deficient practice could affect 25 out of 52 residents. Finding include: On facility tour between 8:30 AM and 12:30 PM on 10/23/2013, observation revealed, that the soiled linen chute has a domestic sprinkler head at top of chute. There is another NFPA 13 fire sprinkler head with-in 6 inches of the domestic fire sprinkler head. This deficient practice was confirmed by Director of Environmental Services (BR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 071		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING **02 - 2013 ADDITION** B. WING _____	**10/23/2013**

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 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY 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 - 2013 addition was found 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 18 New Health Care. This facility will be surveyed as two separate buildings. St. Mark's Lutheran Home - 2013 addition is a 1-story building with no basement. The 2013 addition was determined to be of Type V (111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET:	K 000		

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

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