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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T2EX

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 **12/17/2015** (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
X 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):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 12/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/12/2016 (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

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245369

January 12, 2016

Ms. Susan Johnson, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, MN 55912

Dear Ms. Johnson:

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, 2015 the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 28, 2015

Ms. Camille Rasmussen, Administrator
St. Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, MN 55912

RE: Project Number S5369025

Dear Ms. Rasmussen:

On December 2, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 6, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on October 2, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on November 19, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 17, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 19, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 19, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 19, 2015, as of December 17, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 17, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 2, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 2, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 1, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 2, 2016, is to be rescinded.

In our letter of December 2, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 2, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 17, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245369	A. Building B. Wing	12/17/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0441 Reg. # 483.65 LSC	12/17/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GPN/kfd	**Date:** 12/28/2015	**Signature of Surveyor:** 15425	**Date:** 12/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/2/2015		**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: T2EX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00394

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/19/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 11/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2015 (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

Electronically delivered

December 2, 2015

Ms. Camille Rasmussen, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, MN 55912

RE: Project Number S5369025

Dear Ms. Rasmussen:

On October 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 19, 2015, the Minnesota Department of Health and on November 5, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 2, 2015. The deficiency not corrected is as follows:

F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective December 6, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for

new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 2, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 2, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 2, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Marks Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 2, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Jan.Suzuki@cms.hhs.gov

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

sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 11/19/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on November 19, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	{F 441}		12/3/15

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

Electronically Signed | 12/02/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 11/19/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 1 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to clean the nebulizer equipment between uses for 1 of 3 residents (R29) reviewed for infection control practices. Findings include: R29's Medication Review Report, dated 11/12/15, indicated that the resident had diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation; acute respiratory failure with hypoxia (a deficiency of the amount of oxygen reaching the tissues). R29's Medication Administration Record for the month of November 2015 and reviewed from	{F 441}	1. Corrective Action: A. Resident R. 29. Nursing staff educated on Infection Control Guidelines Policy. B. Resident R 29. Nursing staff educated on proper Administering Medication-Nebulizer and Proper Care of Equipment after administering. C. Nurse responsible has been re - educated and policy has been signed by all nurses. D. Policy is in place 2. Corrective Action as it applies to other residents: A. Nursing staff will be educated and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 11/19/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 2 11/11/15 through 11/19/15 indicated that R29 had been receiving both the Ipratropium-Albuterol Solution and the Tiotropium Bromide Monohydrate Capsules as ordered by the physician. During an observation on 11/19/15 at 9:11 a.m., R29 was lying on her bed in her room. Next to the bed on a bureau was the nebulizer machine. The mask and canister/cup (which holds the medication) were connected to the tubing and the machine. The mask was hanging by a strap on the machine. There appeared to be standing liquid in the canister. There was enough standing liquid to cover the bottom of the canister. When interviewed on 11/19/15 at 9:17 a.m., licensed practical nurse (LPN)-A stated that there was moisture in the canister. LPN-A took the mask and canister and rinsed them under the faucet in the bathroom and placed on a paper towel in order to dry. LPN-A stated that the nebulizer equipment should have been cleaned and dried after R29 received their inhalation medication. LPN-A could not say how long the mask and canister had been like that as she was not the one who administered the inhalation medication. When interviewed on 11/19/15 at 2:03 p.m., the director of nursing (DON) stated that it would be her expectation to have the nebulizer equipment cleaned out after each use. DON also said the nebulizer equipment needed to be cleaned for infection control purposes. The DON stated that the facility had begun audits to ensure that staff had been complying with the requirement of cleaning the nebulizer equipment after each use. She stated that the staff had been trained in this	{F 441}	review Administering medication-Nebulizer and proper care of equipment for all residents. B. Nursing staff will be educated and review Infection Control Guidelines Policy for nebulizer administration. 3. Date of completion: December 12, 2015 4. Reoccurrence will be prevented by: A. Audits will be completed weekly and results shared at Q/A. B. Nursing staff will be educated on policy and procedure as well as policy will be signed by nursing staff to ensure each nurse has been educated and understands. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review the audits on a quarterly and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 11/19/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 3 requirement and they do know they need to do this. Review of the facility policy Administering Medications through a Small Volume (Handheld) Nebulizer (Revised October 2010) stated when the treatment is complete, turn off the nebulizer and disconnect the T-piece, mouthpiece and medication cup. It advised to rinse and disinfect the nebulizer equipment according to facility protocol, or to wash the pieces with warm, soapy water and then to rinse with hot water. Then it advised to place all pieces in a bowl and cover with isopropyl (rubbing) alcohol and to soak for five minutes. Then then pieces should be rinsed with sterile water and allowed to air dry on a paper towel. When the equipment is completely dry, store the pieces in a plastic bag with the resident's name and the date on it.	{F 441}		

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	11/19/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **11/11/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/11/2015**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/11/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/11/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0406** Reg. # **483.45(a)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/11/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/11/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/11/2015**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	12/1/2015	15425	11/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/2/2015

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

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 02 - 20013 ADDITION B. Wing	11/5/2015

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 K0011	Correction Completed 10/07/2015	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 10/07/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GPN/kfd	Date: 12/01/2015	Signature of Surveyor: 15425	Date: 11/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/1/2015		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: T2EX

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 **10/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 11/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 11/12/2015 (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

Electronically delivered

October 21, 2015

Ms. Camille Rasmussen, Administrator
St. Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 55912

RE: Project Number S5369024

Dear Ms. Rasmussen:

On October 2, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 11, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 11, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 2, 2016 (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 2, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

Gary L. Schroeder – Interim Fire Safety Supervisor
Minnesota State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
gary.schroeder@state.mn.us
Office/Cell: 507-361-6204 Fax: 507-282-7899

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		11/11/15

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

Electronically Signed | 10/29/2015

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 _____	10/02/2015

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential abuse to the designated State agency (SA) as required for 5 of 7 residents (R75, R58, R120, R30 and R121) who had reports of potential abuse. Findings include: R75 had an allegation of involuntary seclusion reported to the facility by a nursing assistant (NA)-G on 8-24-15, the alleged incident occurred the previous week between Tuesday and Wednesday during the night shift NA-G worked. The NA-G reported licensed practical nurse (LPN)-D was yelling at R75 to stay in his room. Upon interview LPN-D did admit to placing a chair in front of R75's room and telling R75 to stay in room. The incident was reported to the designated state agency (SA) which is the Office of Health Facility Complaints (OHFC) on 8-24-15	F 225	1. Corrective Action: A. Residents R75, R120, R 58, R121. Staff educated on Abuse and Prevention Policy and steps to report abuse. The steps to report abuse are on each unit as reference. B. All residents listed above had claims filed immediately. 2. Corrective Action as it applies to other residents: A. it is the policy of St. Mark's Living to report all claims of abuse to the DON and administrator immediately. B. Claims will be submitted within 24 hours to MDH and investigated with an investigation report submitted within 5 days of the incident to MDH. 3. Date of completion: November 11th, 2015.	

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 _____	10/02/2015

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 225	Continued From page 2 even though NA-G was a witness of the incident five or six days previously. On 10/01/2015 at 11:29 a.m., licensed social worker (LSW)-A confirmed the vulnerable adult (VA) report was made to the facility by NA-G a week after the alleged incident occurred with R75. LSW-A verified this was a reportable incident and should have been reported immediately to the facility and the SA. LSW-A stated the facility definitely needed to work on education with their staff on reporting timely and what incidents are considered reportable. R58 voiced complaints of rough treatment over the weekend of 5/16/15. On Monday 5/18/15, the registered nurse (RN)-E received a voice message from licensed practical nurse (LPN)-C who worked the weekend stating R58 had complaints of rough treatment over the weekend involving nursing assistant (NA)-H. R58 was interviewed and reported that on Saturday 5/16/15, NA-H had helped her into bed with EZ stand and reported that she was "rough." R58 stated her back hurt during the transfer and reported the NA-H replied "my back hurts too." R58 stated she started to cry. When asked about the incident she stated she wasn't afraid of the NA-H but she was now. The alleged incident occurred on 5-16-15 and the report was made to the SA on 5-18-15. On 10/01/2015 at 11:20 a.m., LSW-A stated a vulnerable adult (VA) report should have been made immediately to the SA. LSW-A verified leaving a voicemail for a nurse to complete the VA report to the SA the following Monday after the alleged incident occurred over the weekend did not follow the policy and procedure to report	F 225	4. Reoccurrence will be prevented by: A. Nursing staff educated on Abuse and Prevention Policy and mandated reporting. B. All staff educated on reporting abuse immediately and review of policy at POC meeting Nov. 3rd, 2015. C. Audits will be completed weekly to assure compliance. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 225	Continued From page 3 immediately to the SA. R120 was observed during a medication administration pass on 9/30/2015 at 7:42 p.m. in his room. R120 stated he was treated roughly by staff, wanted to get out of here and rude staff brings tears to his eyes. Registered nurse (RN)-D was present in room when R120 made these statements. On 10/01/2015 at 10:19 a.m., LSW-A stated she was unaware of the concerns stated by R120 on 9-30-15. LSW-A stated she expected RN-D to report the statements made by R120 that he was treated roughly by staff and rude staff brings tears to his eyes immediately. LSW-A stated the administrator should have been notified and a VA report should have been made immediately to the SA. LSW-A verified the facilities policy and procedure to report immediately to the administrator and SA was not followed. LSW-A verified a VA report was made to the SA on 10-2-15. R30 was interviewed on 9/30/2015 at 1:05 p.m. in her room. R30 reported staff being rough with her sometimes and stated some are better than others. R30 would not provide clear explanation of rough treatment when asked. R30 stated, "I don't want to cause trouble. I think everybody gets along better when I mind my own business. Sometimes I just wish I could tell them to knock it off. But that's all I'm going to say about that and I don't want this going any further." This concern was reported to the facility LSW-A on 9/30/15 at 2:00 p.m. a VA report was made to the SA on 10-2-15 two days after learning of the possible abuse allegation.	F 225		

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 _____	10/02/2015

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 225	Continued From page 4	F 225		

R121's family member (FM)-A shared that on 9/29/2015 at 11:09 a.m. FM-A visited R121 five to six hours a day. FM-A stated she would leave the facility after lunch and stated R121 would be happy, calm and peaceful. FM-A stated in the early evening R121 acted like a totally different person and was no longer happy and calm. FM-A stated R121 had told her staff at the facility were,"mean" to her and also stated R121 was confused at times.

R121 was interviewed on 10/01/2015 at 2:23 p.m. in her room. R121 stated NA-F that just left her room,"drives her nuts, she will even swear at you." R121 stated, "I avoid her if I can and stated she would not be my employee. I would prefer for her not to take care of me." When asked if R121 was afraid of NA-F, R121 stated she was afraid of her mouth and stated NA-F, "is rough when she works with me." NA-F stated she had not shared her concerns with facility staff. This surveyor immediately reported the allegation of abuse to LSW-A on 10/1/15 at 2:51 p.m. However, the alleged abuse had not been reported to SA on 10-2-15 and not immediately.

On 10/02/15 11:32 a.m., LSW-A stated a discussion was held with the director of nursing and administrator and from now on the decision was made to immediately file a report to the SA instead of waiting to meet with the care team to determine if a VA report should be filed. LSW-A stated the director of nursing (DON) told her this morning on 10/2/15 VA reports were being filed on three residents (R120, R30, and R121) who reported rough treatment during the survey process. LSW-A stated the current facility practice was when VA concerns occurred during the weekend a voicemail was left for the charge

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 _____	10/02/2015

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 225	Continued From page 5 nurse and the team would meet and discuss the concern to determine if a VA report needed to be filed the following Monday. LSW-A stated if VA concerns occurred in the evening the concern would be left until the next day for reporting to be made to SA. LSW-A stated, "the facility will be changing the practice as we are aware we are not in compliance with the regulation." On 10/02/2015 11:44 a.m. the administrator verified the facility had not been following the policy and procedure to immediately report allegations of abuse and neglect immediately administrator and SA. Review of the Abuse Prevention Plan for Minnesota SNFS (Skilled Nursing Facilities) undated Policy and procedure, instructed staff to immediately report maltreatment/mistreatment to the facility administrator and the Minnesota Department of Health (Office of Health Facility Complaints Division).	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their written vulnerable adult policies to ensure alleged abuse or mistreatment were immediately reported to the	F 226	1. Corrective Action: A.Residents R75, R 58, R 120, R 121. Staff educated about mandated reporting as well as educated on Abuse prevention	11/11/15

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 _____	10/02/2015

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 226	Continued From page 6 state agency (SA) for 5 of 7 residents (R75, R58, R120, R30 and R121) who reported potential staff mistreatment. Findings include: Review of the Abuse Prevention Plan for Minnesota SNFS (Skilled Nursing Facilities) undated Policy and procedure, instructed staff to immediately report maltreatment/mistreatment to the facility administrator and the Minnesota Department of Health (Office of Health Facility Complaints Division) which is the designated state agency (SA). On 10/02/2015 11:44 a.m. the administrator verified the facility had not been following the policy and procedure to immediately report allegations of abuse and neglect immediately administrator and SA. R75 had an allegation of involuntary seclusion reported to the facility by a nursing assistant (NA)-G on 8-24-15, the alleged incident occurred the previous week between Tuesday and Wednesday during the night shift NA-G worked. The NA-G reported licensed practical nurse (LPN)-D was yelling at R75 to stay in his room. Upon interview LPN-D did admit to placing a chair in front of R75's room and telling R75 to stay in room. The incident was reported to MDH on 8-24-15. On 10/01/2015 at 11:29 a.m., licensed social worker (LSW)-A confirmed the vulnerable adult (VA) report was made to the facility by NA-G a week after the alleged incident occurred with R75. LSW-A verified this was a reportable incident and should have been reported	F 226	policy. B.Steps and criteria to report abuse have been implemented and are placed on each unit as reference. 2.Corrective Action as it applies to other residents: A.It is the policy and procedure of St. Mark¿s to report all claims of abuse and investigate thoroughly. All claims need to be reported to Administrator and DON immediately. B.Claims will be submitted in the time frame allowed to MDH and investigated and investigation report submitted with in the time frame allowed to MDH. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Nursing staff educated on Abuse and mandated reporting B.Immediate reporting to administrator, DON and social services. C.Following the steps and criteria for submitting a claim to MDH. 5.Correction will be monitored by: A. DON or designee B. Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 226	Continued From page 7	F 226		

immediately to the facility and the SA. LSW-A stated the facility definitely needed to work on education with their staff on reporting timely and what incidents are considered reportable.

R58 voiced complaints of rough treatment over the weekend. On Monday 5-18-15, the registered nurse (RN)-E received voice message from the licensed practical nurse (LPN)-C who worked the weekend stating R58 had complaints of rough treatment over the weekend involving nursing assistant (NA)-H. R58 was interviewed and reported that on Saturday 5/16/15, NA-H had helped her into bed with EZ stand and reported that she was "rough". R58 stated her back hurt during the transfer and reported the NA-H replied "my back hurts too." R58 stated she started to cry. When asked about the incident she stated she wasn't afraid of the NA-H but she was now. The alleged incident occurred on 5-16-15 and the report was made to the SA on 5-18-15.

On 10/01/2015 at 11:20 a.m., LSW-A stated a VA report should have been made immediately to the SA. LSW-A verified leaving a voicemail for a nurse to complete the VA report to the SA the following Monday after the alleged incident occurred over the weekend did not follow the policy and procedure to report immediately to the SA.

R120 was observed during a medication administration pass on 9/30/2015 at 7:42 p.m. in his room. R120 stated he was treated roughly by staff, wanted to get out of here and rude staff brings tears to his eyes. Registered nurse (RN)-D was present in room when R120 made these statements.

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 _____	10/02/2015

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 226	Continued From page 8	F 226		

On 10/01/2015 at 10:19 a.m., LSW-A stated she was unaware of the concerns stated by R120 on 9-30-15. LSW-A stated she expected RN-D to report the statements made by R120 he was treated roughly by staff and rude staff brings tears to his eyes immediately. LSW-A stated the administrator should have been notified and a VA report should have been made immediately to the SA. LSW-A verified the facilities policy and procedure to report immediately to the administrator and SA was not followed. LSW-A verified a VA report was made to the SA on 10-2-15.

R30 was interviewed on 9/30/2015 at 1:05 p.m. in her room. R30 reported staff being rough with her sometimes and stated some are better than others. R30 would not provide clear explanation of rough treatment when asked. R30 stated, "I don't want to cause in trouble. I think everybody gets along better when I mind my own business. Sometimes I just wish I could tell them to knock it off. But that's all I'm going to say about that and I don't want this going any further." This concern was reported to the facility LSW-A on 9/30/15 at 2:00 p.m. A VA report was made to the SA on 10-2-15.

R121's family member (FM)-A shared on 9/29/2015 at 11:09 a.m. FM-A visited R121 five to six hours a day. FM-A stated she would leave the facility after lunch and stated R121 would be happy, calm and peaceful. FM-A stated in the early evening R121 acted like a totally different person and was no longer happy and calm. FM-A stated R121 had told her staff at the facility were, mean" to her and stated R121 was confused.

R121 was interviewed on 10/01/2015 at 2:23 p.m.

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 _____	10/02/2015

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 226	Continued From page 9 in her room. R121 stated NA-F that just left her room, "drives her nuts, she will even swear at you." R121 stated, "I avoid her if I can and stated she would not be my employee. I would prefer for her not to take care of me. " When asked if R121 was afraid of NA-F, R121 stated she was afraid of her mouth and stated NA-F, "is rough when she works with me." NA-F stated she had not shared her concerns with facility staff. This concern was reported to the facility LSW-A on 10/1/15 at 2:51 p.m. a VA report was made to the SA on 10-2-15. On 10/02/2015 11:32 a.m., LSW-A stated a discussion was held with the director of nursing and administrator and from now on the decision was made to immediately file a report to the SA instead of waiting to meet with the care team to determine if a VA report should be filed. LSW-A stated the director of nursing (DON) told her this morning on 10-2-15 VA reports were being filed on three residents (R120, R30, and R121) who reported rough treatment during the survey process. LSW-A stated the current facility practice was when VA concerns occurred during the weekend a voicemail was left for the charge nurse and the team would meet and discuss the concern to determine if a VA report needed to be filed the following Monday. LSW-A stated if VA concerns occurred in the evening the concern would be left until the next day for reporting to be made to SA. LSW-A stated, "the facility will be changing the practice as we are aware we are not in compliance with the regulation."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		11/11/15

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 _____	10/02/2015

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 241	Continued From page 10 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain visual privacy for 1 of 1 resident (R31) during transport through a common area from room to shower. Findings Include: R31 was observed on 9/29/15 at 6:59 a.m. sitting in a shower chair in a common area hallway next to room 88. R31 was covered only in a terry cloth poncho; exposing his bare skin on left side. Nursing assistant (NA)-C was yelling down the hall for assistance to transport R31. After sitting next to room 88 for several minutes NA-C then proceeded to transport R31 to the shower room with the assist of NA-B. R31 was admitted to the facility on 3/11/2014 admission record revealed diagnoses to include: Alzheimer's disease [progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills, and behavioral changes], dementia with Lewy Bodies [progressive decline in mental abilities], and Parkinson's disease [progressive disorder of the nervous system that affects movement]. R31's quarterly minimum data set (MDS), dated 8/26/15, revealed a brief interview for mental status score of three indicating a severe cognitive impairment. The MDS also revealed R31 required an extensive one person physical assist with dressing.	F 241	1.Corrective Action: A.Resident R 31. Staff educated on dignity of the residents and Policy on Quality of life-Dignity reviewed. 2.Corrective Action as it applies to other residents: A.Will review Quality of Life- dignity policy for all residents at POC meeting to be held Nov. 3rd, 2015. B.All staff will be educated on resident¿s dignity and quality of life at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.All staff educated on Quality of Life ¿dignity policy B.Audits will be completed weekly and reviewed at quarterly Q/A meetings. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 241	Continued From page 11 On 9/29/15 at 7:10 a.m. NA-B described the procedure for transporting residents through a common area to the shower, "We do ponchos. We are supposed to have two on him. He [R31] had only one, not what we do." NA-B confirmed R31 was exposed on his left side and it was a dignity issue. On 9/25/15 at 7:41 a.m. NA-C stated, "I was missing a second shower cape. I usually work nights and yes I think it is a dignity issue." On 9/30/15 at 7:47 p.m. the director of nursing stated, "They [residents] need to be fully covered, a lot of people prefer the robe or the shower poncho. The poncho should have one or two on them tucked in with nothing exposed." Facility policy, Quality of Life-Dignity dated 2001 revised August 2009, reads "10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 244	1.Corrective Action:	11/11/15

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 _____	10/02/2015

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 244	Continued From page 12 facility failed to resolve resident council grievances in regards to slow call light response time and staff shortage concerns reported to the facility by resident council through meeting minutes. Findings include: Review of the Resident Council meeting minutes revealed the following: -3/23/15 meeting minutes indicated residents main concern had been staff had not answered call lights timely. The minutes read, "Call lights taking too long." -4/27/15 meeting minutes read, "Old business discussed." Follow up regarding call light concern from previous meeting had not been noted in the minutes. Residents main concern had been staff had not answered call lights timely. The minutes read, "Call lights taking too long." -5/18/15 meeting minutes read, "Old business discussed." Follow up regarding call light concern from previous meetings had not been noted in the minutes. Residents main concern had been staff had not answered call lights timely, and staff shortage. The minutes read, "Call lights taking too long. Short staffed." -7/20/15 meeting minutes did not include old business. Follow up regarding call light and staffing concerns from previous meetings had not been noted in the minutes. Residents' main concern had been staff turnover, staff working short and staff had not answered call lights timely. The minutes read, "Staff turnover is concerning and also they felt that everyone is	F 244	A.Residents at resident council. When concerns are brought forward to the activity director they will be written down. B.Activity director will fill out a grievance form with any concerns. C.Residents¿ complaints were addressed and discussed with them individually. D.Staff educated on the importance of answering call lights in a timely manner. E.Staffing has been assessed and facility will create more postings to fit the busy hours on the floors. 2.Corrective Action as it applies to other residents: A.When a resident has a complaint a complaint form will be given to them or filled out with the resident. B.The concerns will then be given to the department heads who will then follow up with the resident. C.All staff will be educated on the call lights at POC meeting Nov. 3rd, 2015 D.Staffing concerns will be addressed at our OC meeting Nov.3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by A.Call light and grievance audits will be completed monthly and results shared at Q/A. B.After monthly resident council meetings Activity director will present to the department heads any resident¿s concerns at our morning stand up	

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 _____	10/02/2015

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 244	Continued From page 13 working short which may be the cause of the turnover. Call lights are taking too long to answer." -9/28/15 meeting minutes did not include old business. Follow up regarding call light and staffing concerns from previous meetings had not been noted in the minutes. On 10/1/15, at 1:01 p.m. the activities director (AD) reported if group concerns are voiced during resident council meetings a copy of the meeting minutes had been given to the department manager appropriate to the concern. AD stated if the concern had continued it would have been discussed at every meeting. AD was unable to provide documentation staff and call light concern follow up had been addressed with resident council. On 10/1/15, at 1:11 p.m. the director of nursing stated she had not received copies of resident council meeting minutes, and had no knowledge resident council members had voiced staff and call light concerns. On 10/1/15, at 1:21 p.m. the administrator stated it had been expected that resident grievances regarding staff and call light be brought to the nurse for investigation and resolution. Administrator verified documentation had not been found that staffing and call light concern from resident council was addressed. Grievance policy revised on 7/8/09 indicated complaints must be investigated within five days of receiving the complaint, and written information must be given as to the outcome of the investigation.	F 244	meeting. C.Staff education on call lights at our POC meeting Nov.3rd, 2015. D.Staffing will be addressed by reviewing the busy times and having more staff available when possible. 5.Correction will be monitored by: A.DON or Designee B.Q/A committee will review audit results on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		11/11/15

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 _____	10/02/2015

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 272	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct an initial comprehensive skin assessment for 1 of 4 residents (R59) reviewed with pressure ulcers. Findings include: R59 was admitted to the facility on 9/3/15, with diagnosis that included non-pressure chronic ulcer of foot, below knee amputation, skin infection, peripheral vascular disease and diabetes mellitus according to the facility admission record. The facility identified R59 on the admission Minimum Data Set (MDS), an assessment dated 9/10/15, to have short and long term memory problem, required extensive assist of one to two staff for activities of daily living, and had 1 unstageable pressure ulcer. The MDS identified R59 was at risk for pressure ulcers, had one or more unhealed pressure ulcers, had one unstageable pressure ulcer with suspected deep tissue injury which was present on admit. Document review of R59's care area assessment (CAA) dated 9/16/15, revealed admitted following left below knee amputation related to infected foot ulcer, one unstageable pressure ulcer due to suspected deep tissue injury, blister on right great toe and second toe. CAA stated R59 refused interventions, staff to observe skin condition with cares and report any suspicious areas for early evaluation and treatment. Document review of the facility resident	F 272	1.Corrective Action: A.Resident R 59. A Comprehensive Skin Assessment was completed immediately. B.Nurses and Nurse Managers educated on Comprehensive Skin Assessment Policy. C.Comprehensive Skin Assessment policy is in place. 2.Corrective Action as it applies to other residents: A.Will review Comprehensive Skin Assessment policy for all residents at POC meeting Nov. 3rd, 2015. B.All staff will be educated on monitoring skin changes and to report per St. Marks Skin Assessment Policy at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Weekly audits and results shared at Q/A B.Nurses and nurse managers educated on Comprehensive Skin Assessment Policy per admission protocol. 5.Correction will be monitored by: A. DON or designee B. Q/A committee will review the audits on a quarterly basis and provide further	

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 _____	10/02/2015

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 272	Continued From page 16 admission/readmission information form dated 9/3/15, identified R59 had below the knee amputation, cast and limb prosthesis. The assessment lacked identification of location of amputation and lacked identification of ulcers. Document review of facility progress notes dated 9/3/15, revealed R59 admitted from hospital with left below knee amputation and cast, alert and oriented, right heel unstageable ulcer, measures 3 centimeters (cm) by 2 cm, no drainage, odor, or redness to area, black blister to right great toe measured 1 cm by 0.7 cm, and 2nd toe right foot 1 cm by 0.3 cm, no drainage. During interview on 10/2/15, at 1:00 p.m., registered nurse-E (RN-E) stated she expected a skin assessment was completed on day of admit to facility. During interview on 10/2/15, at 1:45 p.m., RN-E verified the facility lacked an admission comprehensive skin assessment for R59. She stated she expected the comprehensive skin assessment to be completed by the charge nurse on the evening shift on day of admission. RN-E verified she had made an admission skin note in the facility progress notes on day of admit which stated R59 had right heel ulcer and scabs on great toe and 2nd toe. She verified the the admission/readmission form was blank with no skin assessment. Document review of facility policy Resident Examination and Assessment dated 2/2014, revealed the following: Purpose is to examine and assess resident for any abnormalities in health status which provides a basis for the care plan.	F 272	direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 272	Continued From page 17 Preparation-review the resident's admission and/or primary care plan to assess for any special situations. Physical exam--included "Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes." Documentation-date and time of procedure, name and title of person who performed procedure, all assessment data obtained during procedure, how tolerated, if refused, the reason why and intervention taken, and signature and title of person who recorded the data.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, report, investigate and monitor skin bruising for 1 of 3 residents (R59) reviewed with non-pressure related skin conditions, In addition the facility failed to follow a current physician order for a dressing change for 1 of 3 residents (R21) reviewed for skin conditions, non-pressure related. Findings include:	F 309	1.Corrective Action: A.Resident R 59. Incident report filed immediately. B.Staff educated on Skin Assessment Policy C.Skin policy is in place D.Incident reporting policy is in place. E.Resident R 51. Current wound treatment verified with dr. F.All nursing staff educated on wound care and procedure for clean dressing	11/11/15

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 _____	10/02/2015

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 309	Continued From page 18 LACK OF ASSESSMENT AND MONITORING OF SKIN BRUISE: R59 was admitted to the facility on 9/3/15, with diagnosis that included non-pressure chronic ulcer of foot, below knee amputation, skin infection, peripheral vascular disease and diabetes mellitus according to the facility admission record. The facility identified R59 on the admission Minimum Data Set (MDS), an assessment dated 9/10/15, to have short and long term memory problem, required extensive assist of one to two staff for activities of daily living. No mention of bruising. Document review of nursing assistant bath notes provided by the facility dated 9/4/15 to 10/2/15, revealed no bruising noted. Document review of facility care plan dated 9/17/15, revealed focus of self care deficits. Interventions included skin inspection weekly with showers and as needed, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Observations on 9/30/15, at 5:23 p.m., revealed R59 had a bruise on top of the left hand. Observations on 10/2/15, at 12:20 p.m.,revealed R59 had a large dark purple discoloration on top side of left hand, which covered most of the top side of the hand. During interview at that time, R59 stated had hit hand on the door frame of R59's room.	F 309	changes. 2.Corrective Action as it applies to other residents: A.Will review policy and procedure listed above for all residents at POC meeting Nov. 3rd, 2015. B.Nursing staff will be educated on monitoring for skin changes per St. Marks¿s Skin Assessment Policy at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A. Audits will be completed weekly and results shared at Q/A. B.Nursing staff will be educated on monitoring for skin changes per St. Mark¿s Skin Assessment Policy at POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A. DON or designee B. Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 309	Continued From page 19 During interview on 10/2/15, at 12:55 p.m., registered nurse (RN)-B stated skin was monitored on bath days. RN-B stated she was not aware of any discoloration on R59's left hand. During interview on 10/2/15, at 1:00 p.m., registered nurse (RN)-E stated she was not aware of discoloration on top of left hand. RN-E stated she expected staff to report bruises immediately to the nurse. During observations on 10/2/15, at 1:15 p.m., R59 sat in wheelchair in R59's room. During interview at that time, RN-E verified large dark purple discoloration on top of left hand. During interview at that time, R59 stated had bumped hand on the door frame of R59's room last week. During interview on 10/2/15, at 1:15 p.m., social services (SS)-A director stated she expected staff to immediately report bruises to the nurse. During interview on 10/2/15, at 1:45 p.m., RN-E stated staff were responsible to provide cares for R59. RN-E verified care plan copy dated 9/17/15, was the current care plan. RN-E stated she expected bruises to be reported immediately to the charge nurse. She stated she expected charge nurse investigate, complete an incident report, notified physician and family, and monitor the area until healed. RN-E stated the monitoring could be nurses notes, medication administration record, bath notes or in the skin assessment. She stated any of these forms could "potentially show monitoring." RN-E stated no one was aware of the bruise on left hand. RN-E verified the large discoloration was not reported. RN-E described the area as purple discoloration.	F 309		

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 _____	10/02/2015

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 309	Continued From page 20 During interview on 10/2/15, at 2:00 p.m., nursing assistant (NA)-A stated had provided cares for R59 including assist with dressing, putting on pants and shirt, toileting, and washing. NA-A stated not aware of any bruise or discoloration on left hand. NA-A stated if observed a bruise, would notify nurse right away. During interview on 10/2/15, at 2:05 p.m., NA-D stated had provided cares for R59 including assist with repositioning. NA-D stated not aware of any bruise or discoloration on left hand. NA-D stated if observed a bruise, would notify nurse right away. Document review of facility policy Resident Examination and Assessment dated 2/2014, revealed the following: Purpose is to examine and assess resident for any abnormalities in health status which provides a basis for the care plan. Preparation-review the resident's admission and/or primary care plan to assess for any special situations. Physical exam--included "Skin: a. intactness; b. moisture; c. color; d. texture; and e. presence of bruises, pressure sores, redness, edema, rashes." Documentation-date and time of procedure, name and title of person who performed procedure, all assessment data obtained during procedure, how tolerated, if refused, the reason why and intervention taken, and signature and title of person who recorded the data. LACKED OF FOLLOWING CORRECT DRESSING TREATMENT FOR HEAD WOUND: R21's progress notes, dated 9/9/15 through	F 309		

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 _____	10/02/2015

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 309	Continued From page 21	F 309		

9/29/15 indicated that R21 had a wound on her left anterior head which required treatment.

R21's Treatment Administration Record (TAR) for the month of September 2015 and October 2015 identified the order for the dressing change to R21 ' s left anterior head.

R21's progress notes, dated 9/22/15 contained orders by the physician on the wound treatment for the left anterior head.

A copy of R21's Wound Care Instructions, dated 9/22/15, and signed by the physician, identified the need to leave the Band-Aid on the site (of the left anterior head) for 24 hours, then to remove it; cleanse the area once a day with soap and water (washing hands first); apply Vaseline and cover with Band-Aid; notify the physician if the site becomes infected. In addition, the physician orders also instructed nursing staff to apply vinegar soaks (a method used to treat wounds) to the wound twice a day and to continue until the wound has healed.

On 9/30/15 at 2:29 p.m., R21 was seen to have a Band-Aid on the left temporal area. The Band-Aid was dated 9/28/15.

It was observed on 10/1/15, at 10:43 a.m., R21 had a Band-Aid on the left side of forehead. When asked, R21 stated that the Band-Aid had been there a long time. She stated that it was taking a long time to heal. It was observed that there was no date on the Band-Aid or system to determine if it was replaced every 24 hours per physician orders.

On 10/1/15, at 1:32 p.m., licensed practical nurse

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 _____	10/02/2015

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 309	Continued From page 22	F 309		

(LPN)-A stated that R21 had two separate dressing orders and was trying to find out which order was the correct one.

On 10/1/15, at 1:41 p.m., LPN-A introduced herself to R21 and explained that she was going to do a dressing change at the site of her left anterior head. LPN-A washed her hands. She then put on gloves and sprayed wound cleanser on a clean piece of gauze; she took off the Band-Aid from R21's forehead and wiped with the gauze briefly. LPN-A took off her gloves and washed her hands. LPN-A stated that the wound had been there for some time; she was not sure how R21 had gotten it. LPN-A then put on a new pair of gloves, took a piece of Xeroform (dressing) and cut a piece with a pair of scissors in order to fit the size of the wound so it correctly covered the wound bed. LPN-A then applied a dated and signed Band-Aid. LPN-A then took off her gloves, washed her hands and left the room.

On 10/1/15, at 2:47 p.m., registered nurse (RN)-B stated that the wound had been from a biopsy.

On 10/1/15, at 2:47 p.m., licensed practical nurse (LPN)-A stated that she had performed the wrong dressing treatment instead of the new order dated 9/22/15. She stated she should have done the dressing change according to the orders received on 9/22/15.

On 10/2/15, at 9:28 a.m., the Director of Nursing (DON) stated that the procedure for transcribing new orders is that they first would receive a telephone order from the doctor or wound nurse. That order would then be transcribed in to the computer system and orders would be updated. The DON stated that the nurse who did the

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 _____	10/02/2015

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 309	Continued From page 23 dressing change for R21 should have followed the most current orders as indicated by the physician. Review of the facility's policy titled Wound Care Revised October 2010 stated the need to verify a physician's order for the procedure.	F 309		
F 314 SS=G	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 implement interventions, including repositioning and toileting, based on the comprehensive assessment for 1 of 1 resident (R68) in the sample reviewed who had a current pressure ulcer. This resulted in harm for R68 who had a current stage III (Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer. Findings Include:	F 314	1.Corrective Action: A.Resident R 68. Pressure Ulcer Risk Assessment completed immediately. B.Care plan reviewed with staff and educated on Pressure Ulcers and breakdown. C.Care plan policy, Pressure Ulcer Treatment and Pressure Ulcer Assessment policies are in place. 2.Corrective Action as it applies to other residents: A.Polices reviewed for all residents at POC meeting Nov. 3rd, 2015. B.Staff educated on importance of	11/11/15

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 _____	10/02/2015

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 314	Continued From page 24 During observation on 10/2/15 at 8:04 a.m., R68 was assisted by nursing assistants (NA)-A and NA-E to transfer from her bed to the wheelchair. At 8:16 a.m. NA-A wheeled R68 to the dining room. At 9:27 a.m. R68 was observed sitting in her wheelchair next to the doorway of her room. At 10:45 a.m. R68 was observed sitting in her wheelchair at the balloon-volleyball activity. At 12:41 p.m. (four hours and thirty seven minutes after transfer to wheelchair), R68 was observed sitting in her wheelchair next to the doorway of her room. At 12:58 p.m. R68 was lying in her bed with her eyes closed. On 10/2/15 at 1:26 p.m. registered nurse (RN)-E removed an old duoderm dressing (an opaque dressing for wounds) which covered the stage II pressure ulcer located on the coccyx and it was reddened around edges, open ulcer and approximately 3.5 x 2 centimeters (cm) in size. RN-E treated wound with topical medication and a duoderm dressing to R68's coccyx. R68's quarterly Minimum Data Set (MDS) dated 8/12/15, indicated R68 had severe cognitive impairment, required an extensive two person physical assist with bed mobility and transfer, and had a stage III pressure ulcer. In addition, the quarterly MDS indicated R68 was not able to fully reposition self when in bed or in wheelchair. Documentation on the facility's Weekly Ulcer/Complex Wound Observation Tool included the following measurements for R68's wound: 9/30/15 Coccyx Pressure 1 x 0.3 cm Stage III 9/23/15 Coccyx Pressure 1 x 0.3 cm Stage III 9/16/15 Coccyx Pressure 2 x 0.5 cm Stage III 9/9/15 Coccyx Pressure 3 x 0.7 cm Stage III 9/2/15 Coccyx Pressure 2 x 1 cm Stage III	F 314	following care plans and reporting skin changes per Skin Assessment Policy. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Weekly skin assessment and care plan audits completed with results shared at Q/A B.Staff educated on polices and reporting skin changes at POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A. DON or designee B. Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 314	Continued From page 25 8/26/15 Coccyx Pressure 1 x 0.5 cm Stage III 8/20/15 Coccyx Pressure 2 x 1 cm Stage III 8/15/15 Coccyx 0.5 cm x 0.5 cm blanchable with no pain noted on the Skin Assessment form. Care Plan dated 9/9/15 identified "skin care/pressure ulcer risk" and included intervention of pressure reducing mattress and wheel chair cushion, gentle perineal cares and "Strict every two hour repositioning sitting and laying." On 10/2/15 at 1:32 p.m. NA-A who was assigned cares for R68 for the shift was interviewed and asked if R68 had been repositioned which included offloading (removing pressure to the buttocks area for at least two minutes), since her transfer to the wheelchair at 8:04 a.m. and prior to her transfer back to bed just before 1 p.m.. NA-A said, "No, she hasn't. Sometimes we just put her in her recliner and sometimes we just leave her in her wheelchair all morning to watch TV [television]. Today was a typical day." On 10/2/15 at 1:45 p.m. NA-E who helped with cares for R68 during day shift stated, "Normally you work on your own group [each NA has an assigned group of residents to provide care and services for during their shift], and after lunch we lay [sic] everyone down. No, I did not reposition her [R68] since we got her into her wheelchair this morning." NA-A and NA-E were then asked about R68's care plan for repositioning. NA-E stated, "I think she is every two hours. I don't know with her wound if she is currently one or two. On our point click care tab [computer program] it is every two hours to reposition." NA-A added, "Sometimes it just gets crazy and we don't get to it."	F 314		

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 _____	10/02/2015

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 314	Continued From page 26 On 10/2/15 at 2:41 p.m. the director of nursing (DON) stated, "The expectation is that the care plan is followed. If staff are unsure of what is in it they need to ask the charge nurse, nurse manager, or myself." The DON added that if a resident it to be repositioned every two hours they should be repositioned within that time frame. The facility's policy Pressure Ulcer Treatment revised September 2013, defines a stage II pressure ulcer "Partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister." Stage III pressure ulcer is defined, "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling."	F 314		
F 323 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively investigate causative factors following falls to	F 323	1.Corrective Action: A.Resident R 50. Placed on Hospice Oct. 2nd 2015.	11/11/15

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27 determine resident centered interventions to minimize the risk of further falls for 1 of 3 residents (R50) with history of frequent falls and who had sustained an injury from a fall. This caused harm to R50. Findings include: R50 was observed on 9/30/15 at 1:14 p.m. in bed lying on side, room darkened, and pressure reducing pad in wheelchair. At 3:22 p.m. R50 was in the wheelchair and located in doorway to room. R50 had no shoe or sock on the left foot but did on the right foot. R50's diagnosis located in the current care plan printed 9/11/15, included dementia unspecified with behavioral disturbances, schizoaffective disorder, anxiety,convulsions, generalized pain, depressive disorder. Also was admitted to the facility on 4/13/15 and currently lives in the facility. R50's care plan identified R50 was risk for falling related to dementia with behavioral disturbances, and schizoaffective disorder. The care plan identified R50's history included: balance issues with transfers, self-transfers, hip fracture after fall prior to admission, resistance to cares/abusive behaviors toward staff. The Care Plan included; "Aggressive behavior increases falls risk and risk of injury." The goal was that he would not be injured due to a fall. Fall interventions directed staff to: monitor increased confusion and signs/symptoms acute illness, encourage resident to sit in common area as allows to monitor closely when increased restless/agitation and during the day, remind resident to sit down, provide walker/wheel chair for use, have walker within easy reach, use green gripper pad in	F 323	B.Hospice is working closely with St. Mark¿s on managing his falls and behavioral issues. C.Fall Assessment, Safety and supervision of Resident and Assessing Falls and their cause¿s policies are in place. 2.Corrective Action as it applies to other residents: A.Fall Risk Assessment Policy will be reviewed for all residents at POC meeting Nov. 3rd, 2015. B.Root causative factors and appropriate interventions will be reviewed with IDT. C.Safety and supervision Policy will be reviewed for all residents at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Educating staff and nurses on policies at POC meeting Nov. 3rd, 2015. B.Safety and supervision Policy will be reviewed for all residents at POC meeting Nov. 3rd, 2015. C.Root causative factors and appropriate interventions will be reviewed with IDT. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review the audits on a quarterly basis and provide further	

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28 wheelchair to reduce sliding, encourage use of call light, instruct resident on safety measures, anticipate needs, monitor in bed, frequent checks as needed if restless, attempt to lay down in bed as he allows when viewed sleeping in wheelchair and monitor closely when increased restlessness. The care plan also indicated the resident had a history of seizure disorder and potential for pain related to history of hip fracture. Pain interventions included: monitor pain, establish causative factors and ways to alleviate them. The goal was for R50 to be as comfortable as possible. The care plan further indicated R50 had bowel and bladder incontinence and directed staff to check for incontinence and change pad every two hours and as needed. R50's quarterly Minimum Data Set (MDS) dated 7/28/15, indicated R50 had severe cognitive impairment, and required extensive staff assistance with bed mobility, transferring, locomotion on and off unit and activities of daily living. In addition, the MDS indicated R50 had sustained one fall with injury within the MDS reference period. A Morse Scale Fall Assessment (tool used to determine falls risk) dated 5/1/15, identified R50 was at high risk for falls. Documentation indicated R50 had experienced 11 falls since 3/7/15 as follows: -4/23/15, at 9:00 a.m. R50 found on the floor in his room. Description of incident indicated, "rolled out of bed." No injuries noted. No interventions implemented. 24 hour follow up dated 4/24/15, indicated interventions had been found to be working. Registered nurse (RN) Root	F 323	direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

Cause Analysis identified risk factors/potential causes for fall as "behavior/immobility." Patterns were identified as history of falls. Specific areas identified had been impaired mobility, balance and impaired cognition. RN-E documented an assessment and plan of action which directed staff to continue to monitor resident when restless, and which indicated R50 had history of falls, no injury, and for staff to monitor signs and symptoms of acute illness.

The Root Cause Analysis completed following the fall indicated R50's behavior and immobility had been risk factors and were potential causes of the fall. The report indicated interventions had been found to be working however, there were no specific interventions noted. In addition, no actual causal factors were identified.

-4/23/15, at 9:00 a.m. R50 found on the floor in his room. Description of incident indicated, "rolled out of bed." No injuries noted. No interventions implemented. 24 hour follow up dated 4/24/15, indicated interventions had been found to be working. RN Root Cause Analysis identified risk factors/potential causes for fall as " behavior/immobility." Patterns were identified as history of falls. Specific areas identified had been impaired mobility, balance and impaired cognition. RN-E had documented an assessment and plan of action which directed staff to continue to monitor resident when restless, has history of falls, no injury, monitor signs and symptoms of acute illness.

Root Cause Analysis indicated behaviors and immobility were risk factors and potential causative factors for the fall. The report indicated interventions had been found to be working

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

however, there had been no specific interventions noted. Even though the nurse completed the Root Cause Analysis and had circled Yes or No for areas of Medication, Environment, Functional Status, Psychological, and Underlying illness/condition, there was no resident specific cause of fall from the bed identified, and no interventions identified based on the assessed cause of fall developed.

-5/01/15, at 8:00 a.m. R50 was found sitting on the floor in his room next to his wheelchair. No injuries noted. R50 reported to staff that he had been trying to get to the bathroom and slid from his wheelchair. No interventions implemented. RN Root Cause Analysis identified risk factors/potential causes for fall as "immobility." Specific areas identified had been impaired mobility and behavioral. No patterns had been identified. RN assessment and plan of action directed staff to continue to monitor resident when increased restless, encourage to sit in common area as he allows to monitor closely when increased restless and agitation and during the day. The form was signed as completed by RN-E

Root cause analysis had indicated immobility had been a risk factor and potential cause for the fall. No documentation found that indicated R50's attempt to get to the bathroom had been identified. No actual causal factors were identified even though R50 was attempting to toilet self independently. Report did not identify interventions nor if interventions had been found to be working.

-6/08/15, at 7:00 a.m. R50 was found sitting on the floor in the doorway of his room next to his

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31	F 323		

wheelchair. No injuries noted. No interventions implemented. RN Root Cause Analysis identified risk factors/potential causes for fall as "behavior & mobility." Patterns were identified as history of falls. Specific areas identified had been impaired mobility, change in mood, and behavioral. RN assessment and plan of action indicated R50 had history of increased agitation at times with falls, staff directed to continue to monitor closely when increased agitation, monitor for self-transfers and monitor signs and symptoms of acute illness. The form was signed as completed by RN-E.

Root cause analysis had indicated behavior and immobility had been risk factor and potential cause for the fall. No actual causal factors were identified that may have caused the fall. Report did not identify an new interventions nor if interventions had been found to be working.

-6/18/15, at 1:25 p.m. R50 was found sitting on the floor in his bathroom with pants pulled down. A red mark was noted in the center of R50's forehead. Note on bottom of form directed staff to continue to monitor for increased behaviors, self-transfers and acute signs and symptoms of infection. RN Root Cause Analysis identified risk factors/potential causes for fall as "mobility." No patterns noted. Specific areas identified had been impaired mobility, and impaired cognition. RN assessment and plan of action directed staff to continue to monitor increased behaviors, self-transfers and acute signs and symptoms of infection. The form was signed as completed by RN-E.

Root cause analysis had indicated mobility had been risk factor and potential cause for the fall. No actual causal factors were identified. Report

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32	F 323		

did not identify new interventions nor if care planned interventions had been found to be working.

-6/24/15, at 7:15 a.m. R50 was found sitting on the floor in his room next to his bed. No injuries noted. RN Root Cause Analysis identified no risk factors/potential causes for fall. No patterns had been identified. Specific areas identified had been impaired mobility and behavioral. RN assessment and plan of action read gripper pad in wheelchair to prevent sliding. The form was signed as completed by RN-E. Again no actual causal factors were identified to develop specific interventions to prevent another fall.

-7/17/15, at 1:15 p.m. R50 was found on the floor in his room lying on his right side after staff heard a loud crash and R50 yelling for help. R50 stated he had fallen on his head. One centimeter (cm) x one cm abrasion noted on top of his head, right side. Ice was placed as treatment. Hand written note on bottom of form directed staff to attempt/offer to lay resident down in bed as he allows when viewed sleeping in wheelchair. Continue use of green gripper in wheelchair. RN Root Cause Analysis identified risk factors/potential causes for fall as "mobility." No patterns noted. Specific areas identified had been acute illness, impaired mobility, and behavioral. RN assessment and plan of action directed staff to attempt/offer to lay resident down in bed as he allows when viewed sleeping in chair. Green gripper replaced to wheelchair. Note dated 7/20/15 indicated R50 had been sent to the emergency room for signs and symptoms of respiratory infection and hospitalized. Note indicated acute illness may have contributed to fall. The form was signed as completed by RN-E

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 33	F 323		

Root cause analysis had indicated mobility had been risk factor and potential cause for the fall. No actual causal factors were identified to possible cause of fall. Report did not identify if interventions had been found to be working.

-7/26/15, at 11:10 a.m. R50 was found lying on the floor on his right side with a large puddle of blood under his head. He was located by the bathroom with his wheelchair next to him. A "large laceration" was noted on top of right side of head, staff held pressure on the area and called ambulance. Report indicated R50 appeared to have had a seizure. Interventions implemented included to request doctor to restart medication for seizures. RN Root Cause Analysis identified risk factors/potential causes for fall as " immobility." No patterns noted. Specific areas identified had been recent medication change, impaired mobility, and impaired cognition. RN assessment and plan of action indicated R50 had seizure activity during fall. MD updated to restart seizure meds, fall mattress removed due to increased tripping hazard. The form was signed as completed by RN-E

The Root Cause Analysis for this fall indicated mobility had been a risk factor and potential cause for the fall however, the report indicated he had a medication change, potential seizure and included the removal of fall mattress. There were no new interventions put in place following the return of R50 to the facility even though seizures may have been the cause of fall.

-9/06/15, at 4:30 a.m. R50 was found sitting on the floor in his room. R50 reported to staff that he had been trying to get into his wheelchair when

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 34	F 323		

the fall occurred. No injuries noted. Intervention implemented was for resident to call for assistance with transfers however, R50 is assessed to be severely cognitively impaired. Hand written note on bottom of form directed staff to monitor closely when increased restlessness noted. RN Root Cause Analysis identified immobility as risk factors/potential causes for fall. History of falls identified as a pattern with no specific fall history information. Specific areas identified had been impaired mobility and behavioral. RN assessment and plan of action read to continue to monitor closely when increased restlessness noted.

Root cause analysis had indicated immobility had been risk factor and potential cause for the fall. No actual causal factors were identified. Report did not identify new interventions based on possible cause of fall nor if care planned interventions had been found to be working.

-9/06/15, at 11:15 p.m. R50 was heard yelling out by staff and found lying on the floor in his room on his right side in front of his closet. Juice was noted to be spilled on the floor, and R50 had removed gripper socks from feet. No injuries noted. Hand written note directed staff to monitor for placement of shoes or gripper socks, continue green gripper pad in chair and monitor when increased restlessness. RN Root Cause Analysis identified immobility and mood as risk factors/potential causes for fall. History of falls identified as a pattern with no specific fall history information. Specific areas identified had been impaired mobility and behavioral. RN assessment and plan of action read monitor for placement of shoes or gripper socks, continue gripper pad in chair and monitor when increased restless. The

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 35 form was signed as completed by RN-E. Root cause analysis had indicated immobility and mood had been risk factor and potential cause for the fall. No actual causal factors were identified and no new interventions or if care planned interventions were affective. -9/16/15, at 9:30 a.m. R50 was found in his room sitting on the floor in front of his wheelchair by the bathroom door. No injuries noted. The facility replaced the green gripper pad in R50's wheelchair as intervention to prevent further falls. 24 hour follow up dated 9/17/15 indicated interventions had been found to be working. RN Root Cause Analysis identified immobility as risk factors/potential causes for fall. History of falls identified as a pattern with no specific fall history information. Specific areas identified had been impaired mobility and behavioral. RN assessment and plan of action read green gripper replaced in wheelchair to prevent sliding. Resident has history of self-transfers with falls. The form was signed as completed by RN-E. Root cause analysis had indicated immobility had been risk factor and potential cause for the fall. The facility replaced the green gripper pad as intervention, however, indicated interventions had been found to be working. No actual causal factors were identified. There was no system in place to monitor the placement of the gripper pad. During review of falls, and interview on 10/1/15, at 2:12 p.m. RN-E verified the above findings and further verified tracking and trending had not been completed after each fall. RN-E stated there are no patterns to his falls, he just self-transfers	F 323		

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 _____	10/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 36 and doesn't call. RN-E verified R50 had severe cognitive impairment and indicated the interdisciplinary team reviews falls daily however was unable to provide documentation the above falls had been reviewed. During review of falls, and interview on 10/2/15, at 2:27 p.m. the director of nursing (DON) verified above falls had not been comprehensively assessed for causative factors and appropriate interventions. The facility's policies including fall investigation procedure, were requested but were not provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		11/11/15

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 _____	10/02/2015

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 329	Continued From page 37 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish parameters for as needed (PRN) pain medication for 1 of 5 residents (R38) reviewed for unnecessary medications. Findings Include: R38 was admitted to the facility on 3/20/14, admission record revealed diagnoses to include; unspecified fracture of lumbar and thoracic vertebra. Significant change Minimum Data Set (MDS) dated 8/4/15 revealed a brief interview for mental status score of 6; indicating severe cognitive impairment. R38 was prescribed the following as needed pain medication: acetaminophen [non-narcotic] 500 mg every six hours as needed for pain and oxycodone [opioid narcotic] 2.5 mg every five hours as needed for pain. R38's medication administration record (MAR) revealed 26 doses of as needed oxycodone administered from 9/1/15 through 10/1/15; as needed acetaminophen was not administered. R38's MAR and physician orders lacked parameters of when to give a non-narcotic as	F 329	1.Corrective Action: A.Resident R 38. Pharmacy consultant completed a med review may, 2015. Recommendation was made at that time. Dr. declined stated long history of pain syndrome- previously evaluated at pain clinic. B. Medication Administering Policy is in place. 2.Corrective Action as it applies to other residents: A.Continued service by consultant pharmacist on a monthly basis. B.Continued review of med list by medical director every 60 days. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Continued service by consultant pharmacist on a monthly basis B.Continued med review by medical director every 60 days C. Review Administering Medications Policy for all residents at POC meeting Nov. 3rd, 2015. D. Pharmacist and nursing staff will	

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 _____	10/02/2015

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 329	Continued From page 38 needed pain medication versus when to give an opioid narcotic as needed pain medication. This is typically based on severity of pain based on a five or ten pain scale used to assess pain intensity with the lowest number being minimum pain and top number being excruciating. R38's care plan dated 9/14/15 indicated a focus of behavioral symptoms that included history of narcotic and alcohol abuse, pain, history of vertebral compression fracture secondary to osteoporosis, and complaints of back pain. Goal: be as comfortable as possible. Interventions included monitor pain and administer pain medications as ordered. On 10/2/15 at 12:54 p.m. R38 stated, "I will ask for my oxycodone. They will just give it to me usually." R38 declined to discuss acetaminophen as an affective pain medication. On 10/2/15 at 12:43 p.m. trained medication aide (TMA)-A was asked which as needed medication she would administer to R38; "If he is just having a headache I would give him Tylenol [acetaminophen] but if he was having real bad pain in his back I would offer Oxycodone. I would ask him which he would prefer since he is able to answer his questions." On 10/2/15 at 12:51 p.m. registered nurse (RN)-B stated, "He [R38] will ask for it. I can tell when he is in pain. He will groan. He has scheduled Tylenol. He never asks for the Tylenol he will just ask for the oxy [oxycodone]" On 10/2/15 at 2:45 p.m. the director of nursing (DON) stated, "If the patient is cognitive and alert and can rate pain we would ask which they	F 329	reevaluate PRN use. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review audits on a quarterly basis and will provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 329	Continued From page 39 prefer. If we find out they are are not using one over the other we would discontinue the one that is not being used. He [R38] loves his oxy and we have tried to reduce and have reduced. He was not happy with us and he had behaviors over it. The oxy was scheduled and he became really somnolent we backed off and he became more alert. He was angry when we backed him down." On 10/12/15 at 4:20 p.m. in a phone interview the pharmacy consultant-F stated, "We like to see the patient decide, we would probably like to have this patient have less narcotic. I would like to see something in the books [parameters]. A lot of providers have an in house dictation of when to give which. I know some have something in place. I don't know that St. Mark's has anything in place." Facility policy, Administering Medications dated revised December 2012 "25. If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine the individual as needed, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated."	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		11/11/15

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 _____	10/02/2015

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 334	Continued From page 40 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334		

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 _____	10/02/2015

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 334	Continued From page 41 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document education had been provided prior to administering the influenza immunization for 4 of 5 residents (R17, R31, R37, R38) reviewed for influenza immunizations. R17's influenza immunization was administered on 10/16/14. No documentation of education prior to administration was found or provided. R31's influenza immunization was administered on 10/16/14. No documentation of education prior to the administration was found or provided. R37's influenza immunization was administered on 10/16/14. No documentation of education prior to the administration was found or provided.	F 334	1.Corrective Action: A.Resident R17, R31, R37, R38. Staff educated on educating residents of risks and potential side effects of the influenza vaccine. B.Staff educated on importance of obtaining verbal consent from resident or POA before giving the influenza vaccine. C.When administering the influenza vaccine. Each resident will be given the influenza statement and consent given before receiving the influenza vaccine. D.For all residents the nurse will then document in point click care the Resident¿s name, consent given, date given, education provided, site given, Lot #, Exp. Date.	

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 _____	10/02/2015

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 334	Continued From page 42 R38's influenza immunization was administered on 9/17/14. No documentation of education prior to the administration was found or provided. On 10/2/15 at 2:38 p.m. the director of nurses (DON) stated, "We send a letter out to the family along with the information statement, usually if there is a problem or they don't want us to [administer influenza immunization] they let us know. If we don't hear from them we administer the vaccine. We don't document we mail them out." The DON verified there is no documentation of who the letters are mailed to. The DON provided a copy of the letter she mailed to families, undated and read, Dear Families, Enclosed you will find the vaccine information sheet. This information sheet is provided by the Center of Disease Control that explains the vaccine and risks associated with this vaccine. Please take a moment of your time to look over the enclosed information. If you have any questions or concerns related to the information please feel free to contact me. If you do not want your loved on to receive this vaccine please let St. Mark's know immediately. Letter is signed by the DON. Facility policy Influenza Vaccine revised November 2012, included, 4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record.	F 334	2.Corrective Action as it applies to other residents: A.Educational material will be given to residents or POA prior to giving the influenza vaccine. B.Consent will be obtained from residents or POA before giving the influenza vaccine. C.Staff educated for all residents on influenza prevention policy at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A. Nursing staff will be educated on how to document in point click care the resident¿s name, consent given, date given, education provided, site given, Lot #, Exp. Date. At POC meeting Nov. 3rd, 2015. B. Staff will be educated on the Influenza prevention policy at the POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A.DON or Designee B.Q/A committee will review audits on a quarterly basis and provide further direction if needed.	
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		11/11/15

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 _____	10/02/2015

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 406	Continued From page 43 If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide staff training pertinent to a residents diagnosis for 1 of 2 residents (R75) receiving Pre-Admission Screening and Resident Review (PASRR) Level II services. Findings Include: R75 was admitted to the facility on 3/21/14 admission record revealed diagnoses to include: major depressive disorder severe with psychotic symptoms, traumatic brain injury (TBI), generalized anxiety disorder, and mild cognitive impairment. On 10/1/15 at 4:01 p.m. R75 was sitting at the end of the hallway reading a book. R75 put the book down and stated, "I can't have a pop." repeated statement as he walked towards the 2 pop machines located in the same hallway. Than R75 proceeded to forcefully push each selection on the pop machine while repeating, "I can't have a pop." Staff in the area did not address R75's	F 406	1.Corrective Action: A.Resident R 75. Staff educated on PAS/PASSR screening. B.Facility will set up MI/DD training for all staff Dec. 10th , 2015 2.Corrective Action as it applies to other residents: A.St. Mark¿s policy and procedure for PAS/PASSR screening will be followed for residents who trigger level 2. B. All staff will be educated of upcoming training Dec 10th , 2015 for MI/DD training at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Educating staff of upcoming training and dates for MI/DD training at POC	

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 _____	10/02/2015

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 406	Continued From page 44 reqeust for pop nor redirect him. On 10/2/15 at 1:25 p.m. R75 was yelling loudly in his room, "I just [curse word]" repeatidly and staff in the area did not address yelkling in his room. "i just shit." repeatedly. On 10/2/15 at 8:49 a.m. the social service (SS)-A designated as director was asked about modified training strategies for PASRR level II services provided. SS-A stated, "We do the dementia training. We haven't done any specific MI [mental illness] or DD [developmentally disabled] training. We do it at our all staff training. The county has come out and done training." On 10/2/15 at 11:28 a.m. the human resources director stated, "I do a full day of orientation." The human resources director confirmed the agenda for the orientation does not include MI or TBI. On 10/2/15 at 11:33 a.m. the director of nursing was asked about providing MI or TBI training, "No we don't." On 10/2/15 at 1:01 p.m. SS-A confirmed no TBI or MI training has been provided to staff. "The county came and did dementia training for us it was not MI/DD."	F 406	meeting Nov. 3rd, 2015. B.Following our PAS/PASSR screening policy. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review the audits on a quarterly and will provide further direction if needed.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		11/11/15

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 _____	10/02/2015

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 425	Continued From page 45 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 5 residents (R79) reviewed for unnecessary medications was given psychoactive medication as ordered, and failed to ensure clear physician orders for administration of an antidepressant. Findings include: R79's Physician Progress Note dated 8/6/15, included diagnosis of recurrent depression with severe anxiety and advanced Parkinson w/Lewy body dementia. R79's physician orders dated 8/6/15 included: Sertraline HCl (medication used for depression) 100 milligrams (MG) by mouth (PO) one time a day for depression and clonazepam (medication used to treat anxiety and seizure disorders) 0.5 mg by mouth three times a day for anxiety.	F 425	1.Corrective Action: A.Resident R 75. Correct order obtained and clarified with Dr. B.Accepting Delivery of medication, Administration Medications and Consequences of medication Error Policies are in place. 2.Corrective Action as it applies to other residents: A.Will review the 3 policies mentioned above at POC meeting to be held Nov. 3rd, 2015. B.Nursing staff educated on policies and procedures at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015	

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 _____	10/02/2015

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 425	Continued From page 46 Review of R79's September medication administration record (MAR) identified the following: On 9/11/15 R79's Sertraline HCl dose had been increased to 200 mg po daily. Physicians order for increased dose not found in the record. The facility was unable to provide documentation to reflect why the medication had been increased. Clonazepam had not been given per physicians order on 9/5, 9/6, and 9/7/15, and on 9/8/15 two doses had been missed. Also evening doses had been missed on 9/16 and 9/17/15. A total of 13 missed doses. Nursing progress notes dated 9/5/15 to 9/7/15 indicated the medication had not been available to give. On 9/8/15 nursing progress note read, "Resident has been out of Clonazepam. Called physician today to send refill." When interviewed on 10/2/15, at 2:09 p.m. director of nursing (DON) verified documentation for justification and order to increase Sertraline HCl had not been found in the medical record and further verified missed Clonazepam doses. Facility did not provide a policy that included procedure to order medication and missed doses.	F 425	4.Reoccurrence will be prevented by: A.Weekly audits of e MAR B.Nursing staff educated on policies and procedures at POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A.DON or designee B. Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		11/11/15

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 _____	10/02/2015

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 428	Continued From page 47 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to identify and report this irregularity to the doctor or director of nursing in regards to the lack of parameters for as needed (PRN) pain mediation for 1 of 5 residents (R38) reviewed for unnecessary medications. Findings Include: R38 was admitted to the facility on 3/20/14, admission record revealed diagnoses to include; borderline personality disorder, schizoid personality disorder, alcohol abuse, and unspecified fracture of lumbar and thoracic vertebra. Significant change Minimum Data Set (MDS) dated 8/4/15 revealed a brief interview for mental status score of 6; indicating severe cognitive impairment. R38 was prescribed the following as needed pain medication: acetaminophen [non-narcotic] 500 mg every six hours as needed for pain and oxycodone [opioid narcotic] 2.5 mg every five hours as needed for pain. R38's MAR and physician orders lacked parameters of when to give a non-narcotic as needed pain medication versus when to give an	F 428	1. Corrective Action: A.Resident R 38. Pharmacy consultant completed a med review May, 2015. Recommendation was made at that time. Dr. declined stated long history of pain syndrome- previously evaluated at pain clinic. 2. Corrective Action as it applies to other residents: A.Continued service by consultant pharmacist on a monthly basis. B.Continued review of med list by medical director every 60 days. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Continued service by consultant pharmacist on a monthly basis B.Continued med review by medical director every 60 days 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review audits on a	

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 _____	10/02/2015

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 428	Continued From page 48 opioid narcotic as needed pain medication. R38's medication administration record (MAR) revealed 26 doses of as needed oxycodone was administered from 9/1/15 through 10/1/15; as needed acetaminophen was not administered. Monthly Consultant Pharmacy Medication Review forms reviewed. Form dated 5/13/15 indicated "If PRN oxycodone continues to be used frequently might patient benefit from an adjustment in routine analgesic orders." On 10/12/15 at 4:20 p.m. in a phone interview the pharmacy consultant-F stated, "We like to see the patient decide, we would probably like to have this patient have less narcotic. I would like to see something in the books [regarding to parameters]. A lot of providers have an in house dictation of when to give which. I know some have something in place. I don't know that St. Mark's has anything in place." On 10/13/15 at 8:00 a.m. in a phone interview the pharmacy consultant-E stated, "I took it that they were giving the oxy [oxycodone] for severe pain and Tylenol for mild or moderate pain. The use of oxy was addressed by the pharmacist back in May. To be more clear we have been having difficulty of cleaning up the orders with point click care." Point click care is the facility computerized charting system. Policy was requested but not received.	F 428	quarterly basis and will provide further direction if needed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		11/11/15

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 _____	10/02/2015

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 431	Continued From page 49 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to secure medications from unauthorized access 1 of 1 resident (R40) who received nebulizer treatments.	F 431	1.Corrective Action: A.Resident R 40. Nursing staff educated in regards to Med Administration Policy and Administration of Nebulizer Policy.	

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 _____	10/02/2015

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 431	Continued From page 50 Findings include: R40's Admission Record identified a diagnosis of an intracranial injury without loss of consciousness as well as asthma. R40's quarterly Minimum Data Set (MDS) dated 4/6/15, identified R40 had severe impairment in cognitive function. R40's Medication Review Report, indicated that DuoNeb Solution (a medication used for asthma) 3 milligram (mg) per 3 milliliter (ml): inhale orally every 4 hours as needed for wheezing related to asthma was ordered by the physician on 9/19/13. On 9/30/15, at 3:46 p.m., it was observed that during an interview with R40 in his room, there was liquid in the chamber of the nebulizer cup attached to the mask which was intact and appeared to be ready for use. No nursing staff was present during this interview. When interviewed on 9/30/15, at 3:46 p.m., licensed practical nurse (LPN)-C stated that she had put the DuoNeb medication in the canister in order to administer to R40 at a later time. LPN-C stated that R40 did not have an order to self-administer his own medication. When interviewed on 10/1/15, at 2:27 p.m., the Director of Nursing stated that the DuoNeb medication should not have been set up in advance and left in R40 room for later use. She reiterated she would have expected the nursing staff to administer the medication, disassemble the nebulizer tubing and mask and then clean it out and dry it for its use the next time.	F 431	B.Med Administration Policy and Administration of Nebulizer policy are in place. C.Nurse responsible was educated of policy and procedure. 2.Corrective Action as it applies to other residents: A.Will review policies at POC meeting Nov. 3rd, 2015. B.Nursing staff educated on proper procedure for administering nebulizer and proper care of equipment when finished administering at POC meeting Nov. 3rd, 2015. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Med administration audits will be co0mpleted weekly and results shared at Q/A. B.All staff educated on policies listed above at POC meeting Nov. 3rd, 2015. C.Nursing staff educated on procedures for administering nebulizer and proper care of equipment when finished administering at POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review the audits on a quarterly basis and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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		11/11/15

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 _____	10/02/2015

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 52 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to change gloves during a dressing change after removing a soiled dressing and applying a clean dressing for 1 of 2 residents (R68) observed for a dressing change. In addition the facility failed to clean a nebulizer machine between use for 1 of 1 resident (R14) reviewed for infection control practices. Findings Include: LACK OF FOLLOWING STANDARD INFECTION CONTROL PRACTICES TO PREVENT THE SPREAD OF INFECTION DURING DRESSING CHANGES: R68 had a dressing change on 10/2/15 at 1:26 p.m. completed by registered nurse (RN)-E. RN-E put on clean gloves prior to removing the soiled dressing. The soiled dressing was removed, discarded in the trash. RN-E continued to wear the soiled gloves and measured the wound size, then applied paste with gloves and then applied a clean dressing. R68 was redressed and covered with her bed linens. RN-E wore the same gloves throughout the dressing change removing them only prior to leaving R68's room. On 10/2/15 at 2:41 p.m. the director of nursing (DON) was asked about dressing change expectations, "According to the directions. Absolutely change glove in between dirty and clean dressings." Facility policy, Wound Care revised October 2010 reads, 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and	F 441	1.Corrective Action: A.Resident R. 68 and R 14. Nursing staff educated on Infection Control Guidelines Policy and clean dressing changes procedure. B.Resident R 14. Nursing staff educated on proper Administering Medication-Nebulizer and Proper Care of Equipment after administering. C.Policies are in place 2.Corrective Action as it applies to other residents: A.Nursing staff will be educated and review Administering medication-Nebulizer and proper care of equipment for all residents at POC meeting Nov.3rd, 2015. B.Nursing staff will be educated and review Infection Control Guidelines Policy and dressing change procedures. 3.Date of completion: November 11th, 2015 4.Reoccurrence will be prevented by: A.Audits will be completed weekly and results shared at Q/A. B.Nursing staff will be educated on policies and procedures at POC meeting Nov. 3rd, 2015. 5.Correction will be monitored by: A.DON or designee B.Q/A committee will review the audits on	

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 _____	10/02/2015

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 53 discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves (clean). LACK OF CLEANING NEBULIZER EQUIPMENT BETWEEN USE TO PREVENT INFECTION: R14's Medication Review Report, dated 10/2/15, indicated that R14 had been prescribed DuoNeb Solution 3 milligram (mg) per 3 milliliter (ml): the resident was to inhale orally four times a day related to chronic airway obstruction. A copy of R14's Medication Administration Record (MAR) for the month of September 2015 and October 2015 indicated that R14 had been receiving this medication four times a day. During an observation on 9/29/15, at 11:22 a.m., R14 did have a nebulizer machine (equipment used to administer the ordered DuoNeb medication) along with tubing, a canister/cup (which holds liquid medication) and a mask in the room. The mask, canister and tubing were intact; there was visible fluid in the canister. At 11:22 a.m., on 9/29/15, trained medication aide (TMA)-B was observed to go in to R14's room. When interviewed on 9/29/15, at 11:26 a.m., licensed practical nurse (LPN)-B stated that R14 does self-administer her own nebulizer medication. LPN-B stated that staff would generally go in and prepare the medication to be administered, leave the room and wait for ten minutes, and then go back in to clean the equipment. LPN-B noted that the nebulizer equipment should have been cleaned after it was used last. LPN-B then did go in to R14's room in order to clean the equipment.	F 441	a quarterly and provide further direction if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	10/02/2015

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 54	F 441		

When interviewed on 9/29/15 at 11:43 a.m., R14 stated that TMA-B had just come in and put some more medication in to the capsule of her nebulizer machine. Upon observation, it was noted there was an increased amount of liquid in the canister.

When interviewed on 9/29/15 at 11:49 a.m., trained medication aide (TMA)-B stated that she should have cleaned out the canister and nebulizer equipment prior to adding the new medication to the canister.

When interviewed on 10/1/15 at 2:27 p.m., the Director of Nursing stated that it should not have happened that way. She stated she would have expected the staff to administer the medication, disassemble the mask and equipment and then properly clean and dry for its use the next time.

Review of the facility policy titled Administering Medications through a Small Volume (Handheld) Nebulizer (Revised October 2010), stated the purpose of the procedure was to safely and aseptically administer aerosolized particles of medication into the resident's airway. It stated administer the therapy until medication is gone. When treatment is complete, turn off the nebulizer machine and disconnect the medication cup. Rinse and disinfect the nebulizer equipment according to facility protocol, or: wash pieces with warm, soapy water; rinse with hot water; place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes); rinse all pieces with sterile water (not tap, bottled, or distilled); and allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.

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 _____	10/02/2015

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

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 _____	**10/01/2015**

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	EPOC	

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

Electronically Signed | 10/29/2015

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 _____	**10/01/2015**

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	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

This facility will be surveyed as 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

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 _____	**10/01/2015**

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 56 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 all 15 out 56 residents. Findings include: On facility tour between 12:30 PM and 2:30 PM on 10/01/2015, observation revealed, that the following was found:	K 029	K 29 1. Basement Medical Records room entrance door will not shut and latch. 2. Mechanical/Storage room does not shut and latch. 3. 1st floor South Memory Care room #130 is now being used for storage (over 50 sq. ft.) does not have automatic door closer. As of 10/12/15 both the Medical Records room door and the Mechanical/Storage room door have been adjusted and they now both close	10/12/15

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 _____	**10/01/2015**

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. Basement - medical records room entrance will not shut and latch 2. 1st floor - south memory care, room # 130 is now being used for storage(over 50 sq ft) does not have an automatic door closer 3. Mechanical / storage room(over 50 sq ft) does not shut/latch These deficient practices were confirmed by the Facility Maintenance Director (BR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 029	and latch. They will be monitored by environmental services personnel on an ongoing basis. The South Memory Care room #130 now has spring loaded hinges so it will close automatically .This was completed 10/12/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING **02 - 20013 ADDITION** B. WING _____	**10/01/2015**

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 - 2013 addition 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 18 New 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	K 000	EPOC	

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

Electronically Signed — 10/29/2015

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 **02 - 20013 ADDITION** B. WING _____	**10/01/2015**

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 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as 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 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	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 **02 - 20013 ADDITION** B. WING _____	**10/01/2015**

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 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 18.1.1.4.1. The deficient practice could affect all 15 out 56 residents. Findings include: On facility tour between 12:30 PM and 2:30 PM on 10/01/2015, observation revealed, that the 2 hour fire rated building separation wall between the nursing home and assisted living on 1st floor. The 90 minute fire rated doors did not shut and latch. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 011	K 11 The 2 hour fire separation wall between the Nursing Home and Assisted Living , the 90 minute fire rated door will not shut and latch. The 90 minute door going from the Nursing Home to Assisted Living has been repaired and adjusted by McGough, the contractors who originally put the doors in. This was completed on 10/7/15 and will be monitored by environmental services personnel and also checked monthly when we do our fire drills.	10/7/15
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching	K 018		10/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING **02 - 20013 ADDITION** B. WING _____	**10/01/2015**

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 018	Continued From page 3 hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had a corridor door which were impeded from fully closing and latching into it's frame in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect all 15 out 56 residents. FINDINGS INCLUDE: On facility tour between 12:30 PM and 2:30 PM on 10/01/2015, observation revealed that both sets of double doors from chapel that opens into the corridor will not shut and latch. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 018	K 18 Both Chapel doors opening into the corridor will not shut and latch. Both Chapel doors were adjusted and realigned by McGough, the contractors that originally installed the doors. This was completed on 10/7/15 and will be monitored by environmental services personnel and also be checked monthly when we do our fire drills.	