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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WMOJ

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 **03/02/2015** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/25/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245369

March 16, 2015

Ms. Susan Johnson, Administrator
St Marks Lutheran Home
400 - 15th Avenue Southwest
Austin, Minnesota 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 February 24, 2015 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 2, 2015

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

RE: Project Number S5369024

Dear Ms. Johnson:

On January 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 13, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 24, 2015 and therefore remedies outlined in our letter to you dated January 29, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245369	A. Building B. Wing	3/2/2015

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **02/24/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **02/24/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/24/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/24/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/24/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/24/2015**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/02/2015	10160	03/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245369	A. Building B. Wing **01 - MAIN BUILDING 01**	2/13/2015

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	Correction Completed **02/11/2015**	ID Prefix	Correction Completed **01/19/2015**	ID Prefix	Correction Completed **02/04/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **02/02/2015**	ID Prefix	Correction Completed **02/12/2015**	ID Prefix	Correction Completed **01/31/2015**
Reg. # **NFPA 101** LSC K0071		Reg. # **NFPA 101** LSC K0076		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	03/02/2015	25822	02/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

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	2/13/2015

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 Reg. # NFPA 101 LSC K0050	01/19/2015	ID Prefix Reg. # NFPA 101 LSC K0144	01/31/2015	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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	03/02/2015	25822	02/13/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

March 2, 2015

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

Re: Reinspection Results - Project Number S5369024

Dear Ms. Johnson:

On March 2, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2015, with orders received by you on January 29, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00394	A. Building B. Wing	3/2/2015

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20540** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **02/24/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **02/24/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **02/24/2015**
ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/24/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Sul** LSC	Correction Completed **02/24/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **02/24/2015**
ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/24/2015**	ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Sul** LSC	Correction Completed **02/24/2015**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/02/2015	10160	03/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WMOJ

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 **01/15/2015** (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 02/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/23/2015 (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
January 29, 2015

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

RE: Project Number S5369024

Dear Ms. Johnson:

On January 15, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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
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 February 24, 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 February 24, 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 15, 2015 (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 July 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	01/15/2015

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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and promptly resolve a grievance related to missing personal property for 2 of 2 residents (R23, R15) reviewed for personal property. Findings include: R23's quarterly Minimum Data Set dated 11/8/14, identified she was cognitively intact with a brief interview for mental status (BIMS) score of 13. R23's diagnosis included but was not limited to dementia, anxiety and depression.	F 166	F 166 1. Corrective Action: A. Resident R23 was determined that family took the necklace home 2 years ago. B. Resident R 15. Family contacted and family stated that they are not concerned. 2. Correction action as it applies to other residents: A. It is the policy and procedure of St. Mark□s that missing items tracking forms	2/24/15

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

Electronically Signed | 02/06/2015

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F 166	Continued From page 1 R23's care plan dated 12/7/2006; indicated R23 had impaired cognition related to short term memory loss and history of confusion. On 1/12/15 at 4:43 p.m. R23 reported she had a missing pearl necklace this past summer. R23 reported she informed staff her necklace was missing, stated it didn't seem to matter to them the necklace was missing as nothing was done to locate the necklace. R23's Missing/Broken/Items Tracking form for the pearl necklace was reviewed and revealed R23 reported the necklace missing on 1/29/14, the form was incomplete and an investigation had not been completed for the missing necklace. On 1/14/15 at 10:00 a.m. the licensed social worker (LSW)-A stated R23 reported things missing frequently and staff were usually able to find the missing items or family would state it was not an item R23 had at the facility. LSW-A verified the missing item tracking form for the missing pearl necklace was incomplete and an investigation was not completed. LSW-A verified the facility did not follow the missing item policy and procedure when R23 reported her pearl necklace missing. On 1/15/15 at 10:29 a.m. the director of nurses stated her expectation was the facility would follow the policy and procedure for missing items when a resident reported a missing item. On 1/15/15 at 10:44 a.m. the executive director verified the facility did not follow the policy and procedure for R23's missing pearl necklace and stated an investigation should have been	F 166	will be completed and documented within 5 days of discovery. 3. Date of completion: February 24, 2015 4. Reoccurrence will be prevented by: A. Staff education and training on policy and procedure of missing items will be completed on Feb. 12th, 2015 B. Audits will be completed monthly and results shared at Q/A. 5. Correction will be monitored by: A. Administrator or designee B. Q/A committee will review the audit results on a quarterly basis and provide directions as needed.	

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F 166	Continued From page 2	F 166		

completed.
R15's quarterly Minimum Data Set dated 1/3/15, identified she was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 also R15's diagnosis included but was not limited to Parkinson's disease and diabetes.
R15's care plan dated 8/10/2013; indicated R15 had impaired cognition due to intermittent changes to BIMS scores, intermittent confusion at times requiring verbal cues and times.
On 1/13/15, at 8:45 a.m. R15 reported she had been missing $33.00 out of her dresser some time ago.
R15 reported she had informed staff of her missing money after she had noticed it missing, stated they never got back to me about it and didn't get the money back.
R15's Missing/Broken/Items Tracking form for the $33.00 was reviewed and revealed R15 reported the money missing on 12/4/13, the form was incomplete and an investigation had not been completed for missing money.
On 01/14/15 at 8:49 a.m. the licensed social worker (LSW)-A stated R15 was severely cognitively impaired at the time the money was reported missing and the administrator determined that no further action needed to take place because of the mental status vs. foul play. LSW-A verified a full investigation was not completed for that reason.
The Missing Item Policy dated 6/4/13 read, "Procedure: 1. At the time any item is reported missing a search will be done. The person that was told of the missing item will fill out a missing item report sheet that is located at each nurses station and give missing item form to Social services. 2. Resident Service Director will review missing item sheet and investigate. 3. Resident

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F 166	Continued From page 3 Service Director will contact the resident and their family of missing item and reassure them that a search is being conducted. 4. Resident Service Director will also contact resident and family of outcome of investigation."	F 166		
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	F 272		2/24/15

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F 272	Continued From page 4 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess the need for ongoing nursing home services and need for mental health services for 1 of 1 resident (R82) with identified mental health issues. Findings included: R82 was admitted to the facility with a mental health diagnosis and it was not assessed at the time of the admission Minimum Data Set (MDS) a comprehensive assessment tool. R82's admission Minimum Data Set (MDS) dated 3/28/14 included diagnoses of anxiety disorder, psychotic disorder, neurotic disorders, history of drug abuse, and history of traumatic brain injury (TBI)) and indicated severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of 5. Also was admitted on 3/21/14 from another nursing facility. Admission MDS dated 4/2/14 and the sixty day MDS dated 5/18/14 did not include identification of mental health issues. The quarterly MDS dated 6/24/14, and the quarterly MDS dated 9/24/14 R82 had a serious mental illness or intellectual disability that had been identified on the Preadmission Screening and Resident Review (PASRR) dated 2/20/14 and failed to assess R82 for need of ongoing nursing home care and need	F 272	F272 1. Corrective Action: A. Resident R 82 has been assigned a county worker. B. MDS coding has been corrected C. The county will assign a mental health case manager to evaluate and follow. 2. Corrective Action as it applies to other residents: A. St. Mark□s Policy and Procedure for PAS/PASRR screening will be followed. 3. Date of Completion: February 24th, 2015. Reoccurrence will be prevented by: A. Proper coding of MDS will be reviewed with IDT and those responsible for RAI process. B. Audits will be completed monthly and results shared at Q/A. 5. Corrective will be monitored by: A. DON or designee B. Q/A committee will review the audit results on a quarterly basis and provide	

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F 272	Continued From page 5 for specialized services. The facility also failed to make a referral to the local contact agency. The PASRR dated 2/20/14 indicated R82 had a documented mental illness; psychotic disorder secondary to TBI, required short term nursing home placement for physical and occupational therapy and planned to return to assisted living after completion of therapy. The PASRR read, "Admission is approved: convalescent care following inpatient care for the same condition, less than 30 days stay and includes MD written authorization., and admission has been approved: follow up will be required if extension is needed beyond the specified time limit. " During an interview on 1/15/15, at 9:18 a.m. licensed social worker (LSW)-A verified admission MDS did not address a mental illness for R82.	F 272	further direction as needed.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for monitoring of skin concerns, related to identifying and reporting bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin conditions, in addition the facility failed follow the written care plan to provide nail care for 1 of 3 resident (R15) reviewed for activities of daily living.	F 282	F282 1. Corrective Action: A. Resident R61 and R15. Staff talked to and educated regarding the need to follow POC. B. Resident R61 incident report completed immediately. C. Resident R15 received nail care promptly.	2/24/15

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F 282	Continued From page 6 Findings Include: Lack of monitoring for bruising and timely notification of licensed staff for resident with blood thinner medication: R61 was observed on 1/13/2015 at 8:55 a.m. to have a bruise on the back of his right hand by his wrist with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 1/14/15. R61's significant change in status Minimum Data Set (MDS) dated 11-8-14, identified diagnoses of heart failure, post-traumatic stress disorder and diabetes mellitus. R61 had severe cognitive impairment with a brief interview for mental status score (BIMS) of three and required extensive assist from two staff for activities of daily living, which included mobility and transfers. R61's plan of care dated 10/28/13 read, "Resident receives Coumadin [anticoagulation-blood thinner]." Interventions included "Monitor for signs and symptoms of bleeding." On 1/15/15 at 7:25 a.m. nursing assistant (NA)-A stated she monitored resident skin for bruising when she provided daily cares and reported any bruises to the nurse. NA-A stated on a resident's bath day the nursing assistant and the nurse completed skin inspections. NA-A stated she noticed the bruise on the back of R23's right hand on 1/12/15 in the morning when she checked R61's blood sugar. NA-A stated she did not report the bruise on his hand to the nurse and stated she thought staff was already aware of the	F 282	2. Corrective action as it applies to other residents: A. Will review Policy and procedure for all residents at the POC meeting to be held Feb. 12th, 2015. B. All staff will be educated on monitoring nails and report need for nail care to nursing staff at the POC meeting Feb 12th, 2015. C. Nursing staff will be educated on monitoring for skin changes per St. Mark□s Skin Assessment Policy at POC meeting Feb. 12th, 2015. 3. Date of Completion: February 24th 2015. 4. Reoccurrence will be prevented by: A. Audits will be completed weekly and results shared at Q/A. B. All staff will be educated on monitoring nails and report need for nail care to nursing staff at the POC meeting Feb 12th, 2015. C. Nursing staff will be educated on monitoring for skin changes per St. Mark□s Skin Assessment Policy at POC meeting Feb. 12th, 2015. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review the audit results on a quarterly basis and provide further direction as needed.	

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F 282	Continued From page 7 bruise. Review of the nurse progress note completed by RN-A dated 1/14/15 read, "This nurse notified of bruise to resident's RT [right] hand. Resident has a bruise (dark purple) to RT [right] hand on top of hand between thumb and first finger. Charge nurse aware. Bruise is irregular is irregular shape and measures 5 x 4 cm [centimeters] ..." On 1/15/15 10:33 a.m. the director of nursing (DON) stated she expected staff to check resident skin during cares daily and report any skin issues to the charge nurse. The DON stated the nurse should then measure and note color of the bruise, interview the resident regarding the bruise and complete an incident report. The DON verified the facility did not follow R61's care plan for monitoring of residents skin for bleeding. Lack of nail care for resident dependent on staff to meet activities of daily living skills (ADLs): R15 was observed on 01/13/15, at 8:52 a.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. R15 was observed on 1/14/15, at 2:30 p.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. Again on 1/15/15, at 8:28 a.m. sitting at the dining room breakfast table. R15's fingernails had brown/black debris underneath fingernails on both hands. R15's quarterly Minimum Data Set (MDS) dated 12/17/14, identified diagnoses of Parkinson's disease and diabetes. R15 had moderate cognitive impairment with a brief interview for mental status score of 11 and required extensive assist from one staff for activities of daily living, which included dressing and hygiene.	F 282		

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F 282	Continued From page 8 R15's current copy of the care plan identified R15 had a self-care deficit related to Parkinson's and required extensive assist of one staff for grooming. The care plan identified R15's diagnosis of diabetes with an intervention of nursing to provide nail care. During an interview on 1/15/15, at 7:26 a.m. licensed practical nurse (LPN)-D stated nail care was provided on shower days and as needed. R15's shower day is scheduled for Tuesdays. During an interview on 1/15/15, at 7:28 a.m. nursing assistant (NA)-C stated nail care was usually done after showers or after breakfast. NA-C explained if people are diabetic then the foot doctor cuts the nails but the aides clean them. NA-C stated she was trying to get the nail care caught up. NA-C stated R15 had always been cooperative with nail care. During an interview on 1/15/15, at 8:35 a.m. RN-B verified residents that are care planned extensive assist with hygiene included needing extensive assist with nail care. Facility policy Nursing Care Standards last review date of 5/11 read, "Fingernails and toenails shall be clean and trimmed." The facility provided a copy of a MED-PASS, Inc. procedure (last revised October 2010) Care of Fingernails/Toenails read, "the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections., and Nail care includes daily cleaning and regular trimming." The procedure provided indicated documentation that should be recorded in the medical record is " The date and time that nail care was given, name and title of individual who administered the nail care. and The condition of the resident's nail and nail bed ...."	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		2/24/15

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F 309 SS=D	Continued From page 9 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 bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin conditions. Findings Include: R61 was observed on 1/13/2015 at 8:55 a.m. to have a bruise on the back of his right hand by his wrist with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 1/14/15. R61's significant change in status Minimum Data Set (MDS) dated 11-8-14, identified diagnoses of heart failure, post-traumatic stress disorder and diabetes mellitus. R61 had severe cognitive impairment with a brief interview for mental status score (BIMS) of three and required extensive assist from two staff for activities of daily living, which included mobility and transfers. R61's plan of care dated 10/28/13 read, " Resident receives Coumadin. " Interventions included: " Monitor for signs and symptoms of bleeding. "	F 309	F309 1. Corrective Action: A. Resident R61 incident report completed immediately. B. Staff reeducated on Skin Assessment Policy C. Skin Assessment Policy is in place. 2. Corrective Action as it applies to other residents: A. Will review Policy and procedure for all residents at the POC meeting to be held Feb. 12th, 2015. B. Nursing staff will be educated on monitoring for skin changes per St. Mark□s Skin Assessment Policy at POC meeting Feb. 12th, 2015. 3. Date of Completion: February 24th, 2015. 4. Reoccurrence will be prevented by: A. Audits will be completed weekly and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 R61's January 2015 progress notes and weekly skin audits were reviewed and there was no documentation in regards to the bruise on the back his right hand. On 12/17/14 at 2:55 p.m. nursing assistant (NA)-D stated she monitored resident skin for bruising when providing cares daily and reported any bruises to the nurse right away. On 1/15/15 at 7:25 a.m. nursing assistant (NA)-A stated she monitored resident skin for bruising when she provided daily cares and reported any bruises to the nurse. NA-A stated on a resident ' s bath day the nursing assistant and the nurse completed skin inspections. NA-A stated she noticed the bruise on the back of R23 ' s right hand on 1/12/15 in the morning when she checked R61 ' s blood sugar. NA-A stated she did not report the bruise on his hand to the nurse and stated she thought staff was already aware of the bruise. On 1/14/15 at 1:49 p.m. registered nurse (RN)-A verified there was no documentation completed in the medical record for the bruise on the back of R61 ' s right hand and verified an incident report had not been completed. Review of the nurse progress note completed by RN-A dated 1/14/15 read, " This nurse notified of bruise to resident ' s RT [right] hand. Resident has a bruise (dark purple) to RT [right] hand on top of hand between thumb and first finger. Charge nurse aware. Bruise is irregular is irregular shape and measures 5 x 4 cm [centimeters] ... "	F 309	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 Feb. 12th, 2015. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review the audit results on a quarterly basis and provide further direction as needed.	

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	245369	A. BUILDING _____ B. WING _____	01/15/2015

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F 309	Continued From page 11 On 1/15/15 10:33 a.m. the director of nursing (DON) stated she expected staff to check resident skin during cares daily and report any skin issues to the charge nurse. The DON stated the nurse should then measure and note color of the bruise, interview the resident regarding the bruise and complete an incident report. The DON verified the facility did not follow R61 ' s care plan for monitoring of residents skin for bleeding. A policy for monitoring of non-pressure related skin conditions was requested and not provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 1 resident (R15) who required extensive staff assistance to maintain grooming and hygiene needs. Findings included: R15 was observed on 01/13/15, at 8:52 a.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. Again on 1/14/15, at 8:30 a.m. sitting in her room R15 ' s fingernails had brown/black debris underneath fingernails on both hands even though R15 had a shower on 1/13/205. Again on 1/15/15, at 8:28 a.m. sitting at the dining room breakfast table R15's fingernails had brown/black	F 312	F312 1. Corrective Action: A. Resident R15 received nail care promptly. B. Staff educated on proper nail care and St. Mark□s Policy and Procedure reviewed. 2. Corrective action as it applies to other residents: A. Will review Policy and procedure for all residents at the POC meeting to be held Feb. 12th, 2015. B. All staff will be educated on monitoring	2/24/15

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F 312	Continued From page 12 debris underneath fingernails on both hands. R15's quarterly Minimum Data Set (MDS) dated 12/17/14, identified diagnoses of Parkinson's disease and diabetes. R15 had moderate cognitive impairment with a brief interview for mental status score of 11 and required extensive assist from one staff for activities of daily living, which included dressing, grooming and hygiene needs. R15's current copy of the care plan identified R15 had a self-care deficit related to Parkinson's and required extensive assist of one staff for grooming. The care plan identified R15's diagnosis of diabetes with an intervention of nursing to provide nail care. During an interview on 1/15/15, at 7:26 a.m. licensed practical nurse (LPN)-D stated nail care was provided on shower days and as needed. R15's shower day is scheduled for Tuesdays (done 1/13/2015). During an interview on 1/15/15, at 7:28 a.m. nursing assistant (NA)-C stated nail care was usually done after showers or after breakfast. NA-C explained if people are diabetic then the foot doctor cuts the nails but the aides clean them. NA-C stated she was trying to get the nail care caught up. NA-C stated R15 had always been cooperative with nail care. During an interview on 1/15/15, at 8:35 a.m. RN-B verified R15 needed assistance with nail care. Facility policy Nursing Care Standards last review date of 5/11 read, "Fingernails and toenails shall be clean and trimmed." The facility provided a copy of a MED-PASS, Inc. procedure (last revised October 2010) Care of Fingernails/Toenails. The procedure read, "The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent	F 312	nails and report need for nail care to nursing staff at the POC meeting Feb 12th, 2015. 3. Date of Completion: February 24th, 2015. 4. Reoccurrence will be prevented by: A. Audits will be completed weekly and results shared at Q/A. B. All staff will be educated on monitoring nails and report need for nail care to nursing staff at the POC meeting Feb 12th, 2015. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review the audit results on a quarterly basis and provide further direction as needed.	

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F 312	Continued From page 13 infections., and Nail care includes daily cleaning and regular trimming."	F 312		
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 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess the effectiveness of Omeprazole to control gastrointestinal reflux disease for 1 of 5 residents (R82) reviewed for unnecessary medications.	F 329	F329 1. Corrective Action: A. Resident R82 pharmacist consultant completed a med review 1/22/2015 of	2/24/15

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F 329	Continued From page 14 Findings included: R82's admission Minimum Data Set (MDS) dated 11/10/2014 included a diagnosis of gastro-esophageal reflex disease (GERD) and indicated severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of 2. R82's admission physician orders dated 3/21/14 included, "Omeprazole [belongs to group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach] 20 milligrams (mg) by mouth one tab two times a day one half hour before meals for esophageal reflux. " R82's current physician orders provided by the facility on 1/14/15 included Omeprazole 20 mg by mouth one tab two times a day and has received for the past 8 plus months. R82's care plan dated 4/14/14 indicated resident was at risk for alteration in nutritional status related to several factors that included GERD. Physician's visit note dated 5/22/14, 6/18/14, 10/23/14 and 12/11/14 all dates read the same, " Reflux. Continue Omeprazole." During an interview on 1/15/15, at 10:03 a.m. licensed practical nurse (LPN)-D stated R82 had not complained of gastrointestinal upset and LPN-D was not aware of how GERD was being monitored or assessed to determine if Omeprazole was affective. During an interview on 1/15/15 at 10:05 a.m. registered nurse (RN)-A stated, nursing did not have a specific assessment for GERD and nursing did not assess or monitor if the Omeprazole was affective for treating GERD. RN-A continued to say any information regarding monitoring of Omeprazole probably would be found in the physician's notes.	F 329	Omeprazole (recommendation was to continue). B. Medical Director reviewed need for Omeprazole for Dx. of GERD. 2. Corrective action as it applies to other residents: A. Continued service by consultant pharmacist on a monthly basis B. Continue review by Medical director every 60 days . 3. Date of completion February 24th, 2015 4. Reoccurrence will be prevented by: A. Continue d service by consultant pharmacist on a monthly basis B. Continue review by Medical director every 60 days. C. Will review recommendations at quarterly Q/A meeting. 5. Correction will be monitored by: A. DON or designee B. Q/A committee will review the audit results on a quarterly basis and provide further direction as needed.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2015

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.

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K 000	Continued From page 1 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	K 000		

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour fire rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect all 15 out 54 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, observation revealed, that the 90 minute fire rated door from Long Term Care to Apartment building does not positively latch. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of	K 011	On Wednesday 2/11/15 Johnson Harware Company will be here to redo our door so it is a positive latching door. This will be completed that day, 2/11/15	2/11/15

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K 011	Continued From page 3 discovery.	K 011		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 54 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, the review of the fire drill documentation for the past 12 months (January 2014 to December 2014) revealed that the drills for the day shifts were completed but did not sufficiently vary the times that the drills were conducted - 0915, 1000, 1230 and 0900 hours. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of	K 050	The 2015 Fire Drill Schedule has been redone so every drill is at least 1 1/2 hours apart for each drill on each shift per quarter. This was completed on 1/19/2015 and will be scheduled like this yearly going forward.	1/19/15

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K 050	Continued From page 4 discovery.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, as well as 1999 NFPA 13 section 5-7.4.1.1 and 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 15 out of 42 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, observation revealed that the following was found: 1. Oxygen storage room - the sidewall sprinkler head is located less than 4 inches from ceiling 2. Spare sprinkler head box - does not contain (2) spare sprinkler heads of each type These deficient practices were confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 062	1. on 2/4/15 Summit Fire Protection supplied us with one type of sprinkler head we we'er missing and also an extra box to keep them in. 2. On 1/27/15 Summit Fire Protection came in and moved the sprinkler head to 4 inches below the ceiling.	1/27/15
K 071	NFPA 101 LIFE SAFETY CODE STANDARD	K 071		2/2/15

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K 071 SS=F	Continued From page 5 Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observations, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and 1999 NFPA 82. This deficient practice could affect 35 out of 54 residents Finding include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, observation revealed, that the following was found:	K 071	1. A new chute door was ordered on 2/2/15 from ChuteDr.com and will be istalled as soon as it arrives. 2. A new bottom fire rated fusible link door has been ordered from ChuteDr.com on 2/2/15 and will be installed as soon as it arrives. We will update completion date when it is completed	

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K 071	Continued From page 6 1. 1st floor chute loading door has been removed and the room the chute is located in is not a 1 hour fire rate room 2. Basement - bottom chute door is not a 1 hour fire rated door and does not have a fusible link on the door These deficient practices were confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 071		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has oxygen cylinders not properly stored in compliance with the requirements of 1999 NFPA 99, Sections 4-3.1.1.2. This deficient practice could affect all 35 out of 54 residents. Findings include:	K 076	1. This was checked and verified by the lead Maintenance man Gary Hastings that yes, teh room is vented directly to the outside and is now labeled as such. This was done on 1/19/2015 2. On 1/16/2015 North West Respiratory	1/20/15

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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2015**

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 076	Continued From page 7 On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, observation revealed that in the oxygen store room over 3000 cubic feet in the Golden Oak wing, the following was found: 1. unknown if room is vented directly to the outside 2. one "E" cylinder that is not properly secured 3. combustible empty boxes and trash in room 4. light switch is located less than 5 feet off of floor These deficient practices were confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 076	Services brought us more holders for our E Cylinders. Staff was also informed to always put Cylinders int eh holders. Also there is an ALL STAFF Mandatory plan of Corrections meeting on 2/12/2015 and again all staff will be educated on this. This will be monitored by both the Enviromental Services Director and Maintenance personal. 3. All Empty boxes and trash was removed from this area on 1/16/2015 and staff was instructed not to leave any trash or boxes in this area. This will be monitored by Enviromental Services Director and Maintenance personnel staff and all staff will be educated at the all staff meeting 2/12/2015. 4. On 1/20/2015 Fox Electric moved teh light switch up to 5 feet of the floor.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency	K 144	The thermostat on this generator was changed out by Fox Electric on 1/31/2015	1/31/15

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 _____	**01/15/2015**

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 144	Continued From page 8 generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. This deficient practice could affect all 54 residents Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, documentation review of the monthly emergency generator testing logs (January 2014 to December 2014), indicated that the facility did not run the # 3 natural gas emergency generator by one of the following: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating; (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer 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 144	and now meets the manufractures specifications.	

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 _____	**01/15/2015**

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

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K 000	INITIAL COMMENTS 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		02/09/2015

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 _____	**01/15/2015**

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

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K 000	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 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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

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K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 54 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, the review of the fire drill documentation for the past 12 months (January 2014 to December 2014) revealed that the drills for the day shifts were completed but did not sufficiently vary the times that the drills were conducted - 0915, 1000, 1230 and 0900 hours. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 050	The 2015 Fire Drill Schedule has been redone so every drill is at least 1 1/2 hours apart for each drill on each shift per quarter. This was completed on 1/19/2015 and will be scheduled like this yearly going forward.	1/19/15
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		1/31/15

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	245369	A. BUILDING **02 - 20013 ADDITION** B. WING _____	**01/15/2015**

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K 144	Continued From page 3 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. This deficient practice could affect all 54 residents Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/15/2015, documentation review of the monthly emergency generator testing logs (January 2014 to December 2014), indicated that the facility did not run the # 3 natural gas emergency generator by one of the following: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating; (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 144	The thermostat on this generator was changed out by Fox Electric on 1/31/2015 and now meets the manufractures specifications.	

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K 144	Continued From page 4 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 29, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5369024

Dear Ms. Johnson:

The above facility was surveyed on January 12, 2015 through January 15, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	01/15/2015

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On Janury 12, 13, 14, & 15, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		2/24/15

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess the need for ongoing nursing home services and need for mental health services for 1 of 1 resident (R82) with identified mental health issues. Findings included: R82 was admitted to the facility with a mental health diagnosis and it was not assessed at the time of the admission Minimum Data Set (MDS) a comprehensive assessment tool. R82's admission Minimum Data Set (MDS) dated 3/28/14 included diagnoses of anxiety disorder, psychotic disorder, neurotic disorders, history of drug abuse, and history of traumatic brain injury (TBI)) and indicated severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of 5. Also was admitted on 3/21/14 from another nursing facility. Admission MDS dated 4/2/14 and the sixty day MDS dated 5/18/14 did not include identification of mental health issues. The quarterly MDS dated 6/24/14, and the quarterly MDS dated 9/24/14 R82 had a serious mental illness or intellectual disability that had been identified on the Preadmission Screening and Resident Review (PASRR) dated 2/20/14 and failed to assess R82 for need of ongoing nursing home care and need for specialized services. The facility also failed to make a referral to the local contact agency. The PASRR dated 2/20/14 indicated R82 had a documented mental illness; psychotic disorder secondary to TBI, required short term nursing home placement for physical and occupational therapy and planned to return to assisted living after completion of therapy. The PASRR read,	2 540	Completion Date: February 24th, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 4 "Admission is approved: convalescent care following inpatient care for the same condition, less than 30 days stay and includes MD written authorization., and admission has been approved: follow up will be required if extension is needed beyond the specified time limit." During an interview on 1/15/15, at 9:18 a.m. licensed social worker (LSW)-A verified admission MDS did not address a mental illness for R82. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to comprehensive assessments and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for monitoring of skin concerns, related to identifying and reporting bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin conditions, in addition the facility failed follow the written care plan to provide nail care for 1 of 3 resident (R15)	2 565	Completion date: February 24th, 2015	2/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LUTHERAN HOME	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 reviewed for activities of daily living. Findings Include: Lack of monitoring for bruising and timely notification of licensed staff for resident with blood thinner medication: R61 was observed on 1/13/2015 at 8:55 a.m. to have a bruise on the back of his right hand by his wrist with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 1/14/15. R61's significant change in status Minimum Data Set (MDS) dated 11-8-14, identified diagnoses of heart failure, post-traumatic stress disorder and diabetes mellitus. R61 had severe cognitive impairment with a brief interview for mental status score (BIMS) of three and required extensive assist from two staff for activities of daily living, which included mobility and transfers. R61's plan of care dated 10/28/13 read, "Resident receives Coumadin [anticoagulation-blood thinner]." Interventions included "Monitor for signs and symptoms of bleeding." On 1/15/15 at 7:25 a.m. nursing assistant (NA)-A stated she monitored resident skin for bruising when she provided daily cares and reported any bruises to the nurse. NA-A stated on a resident's bath day the nursing assistant and the nurse completed skin inspections. NA-A stated she noticed the bruise on the back of R23's right hand on 1/12/15 in the morning when she checked R61's blood sugar. NA-A stated she did not report the bruise on his hand to the nurse and stated she thought staff was already aware of the	2 565		

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	00394	A. BUILDING: _____ B. WING _____	01/15/2015

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2 565	Continued From page 6 bruise. Review of the nurse progress note completed by RN-A dated 1/14/15 read, "This nurse notified of bruise to resident's RT [right] hand. Resident has a bruise (dark purple) to RT [right] hand on top of hand between thumb and first finger. Charge nurse aware. Bruise is irregular is irregular shape and measures 5 x 4 cm [centimeters] ..." On 1/15/15 10:33 a.m. the director of nursing (DON) stated she expected staff to check resident skin during cares daily and report any skin issues to the charge nurse. The DON stated the nurse should then measure and note color of the bruise, interview the resident regarding the bruise and complete an incident report. The DON verified the facility did not follow R61's care plan for monitoring of residents skin for bleeding. Lack of nail care for resident dependent on staff to meet activities of daily living skills (ADLs): R15 was observed on 01/13/15, at 8:52 a.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. R15 was observed on 1/14/15, at 2:30 p.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. Again on 1/15/15, at 8:28 a.m. sitting at the dining room breakfast table. R15's fingernails had brown/black debris underneath fingernails on both hands. R15's quarterly Minimum Data Set (MDS) dated 12/17/14, identified diagnoses of Parkinson's disease and diabetes. R15 had moderate cognitive impairment with a brief interview for mental status score of 11 and required extensive assist from one staff for activities of daily living, which included dressing and hygiene.	2 565		

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2 565	Continued From page 7 R15's current copy of the care plan identified R15 had a self-care deficit related to Parkinson's and required extensive assist of one staff for grooming. The care plan identified R15's diagnosis of diabetes with an intervention of nursing to provide nail care. During an interview on 1/15/15, at 7:26 a.m. licensed practical nurse (LPN)-D stated nail care was provided on shower days and as needed. R15's shower day is scheduled for Tuesdays. During an interview on 1/15/15, at 7:28 a.m. nursing assistant (NA)-C stated nail care was usually done after showers or after breakfast. NA-C explained if people are diabetic then the foot doctor cuts the nails but the aides clean them. NA-C stated she was trying to get the nail care caught up. NA-C stated R15 had always been cooperative with nail care. During an interview on 1/15/15, at 8:35 a.m. RN-B verified residents that are care planned extensive assist with hygiene included needing extensive assist with nail care. Facility policy Nursing Care Standards last review date of 5/11 read, "Fingernails and toenails shall be clean and trimmed." The facility provided a copy of a MED-PASS, Inc. procedure (last revised October 2010) Care of Fingernails/Toenails read, "the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections., and Nail care includes daily cleaning and regular trimming." The procedure provided indicated documentation that should be recorded in the medical record is " The date and time that nail care was given, name and title of individual who administered the nail care. and The condition of the resident's nail and nail bed ...." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring	2 565		

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2 565	Continued From page 8 system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify bruises for 1 of 3 residents (R61) reviewed for non-pressure related skin conditions. Findings Include: R61 was observed on 1/13/2015 at 8:55 a.m. to have a bruise on the back of his right hand by his wrist with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 1/14/15.	2 830	Completion Date: February 24th, 2015	2/24/15

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2 830	Continued From page 9 R61's significant change in status Minimum Data Set (MDS) dated 11-8-14, identified diagnoses of heart failure, post-traumatic stress disorder and diabetes mellitus. R61 had severe cognitive impairment with a brief interview for mental status score (BIMS) of three and required extensive assist from two staff for activities of daily living, which included mobility and transfers. R61's plan of care dated 10/28/13 read, " Resident receives Coumadin. " Interventions included: " Monitor for signs and symptoms of bleeding. " R61's January 2015 progress notes and weekly skin audits were reviewed and there was no documentation in regards to the bruise on the back his right hand. On 12/17/14 at 2:55 p.m. nursing assistant (NA)-D stated she monitored resident skin for bruising when providing cares daily and reported any bruises to the nurse right away. On 1/15/15 at 7:25 a.m. nursing assistant (NA)-A stated she monitored resident skin for bruising when she provided daily cares and reported any bruises to the nurse. NA-A stated on a resident ' s bath day the nursing assistant and the nurse completed skin inspections. NA-A stated she noticed the bruise on the back of R23 ' s right hand on 1/12/15 in the morning when she checked R61 ' s blood sugar. NA-A stated she did not report the bruise on his hand to the nurse and stated she thought staff was already aware of the bruise. On 1/14/15 at 1:49 p.m. registered nurse (RN)-A verified there was no documentation completed in the medical record for the bruise on the back of	2 830		

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2 830	Continued From page 10 R61 ' s right hand and verified an incident report had not been completed. Review of the nurse progress note completed by RN-A dated 1/14/15 read, " This nurse notified of bruise to resident ' s RT [right] hand. Resident has a bruise (dark purple) to RT [right] hand on top of hand between thumb and first finger. Charge nurse aware. Bruise is irregular is irregular shape and measures 5 x 4 cm [centimeters] ... " On 1/15/15 10:33 a.m. the director of nursing (DON) stated she expected staff to check resident skin during cares daily and report any skin issues to the charge nurse. The DON stated the nurse should then measure and note color of the bruise, interview the resident regarding the bruise and complete an incident report. The DON verified the facility did not follow R61 ' s care plan for monitoring of residents skin for bleeding. A policy for monitoring of non-pressure related skin conditions was requested and not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs	2 920		2/24/15

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2 920	Continued From page 11 Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 1 resident (R15) who required extensive staff assistance to maintain grooming and hygiene needs. Findings included: R15 was observed on 01/13/15, at 8:52 a.m. sitting in her room. R15's fingernails had brown/black debris underneath fingernails on both hands. Again on 1/14/15, at 8:30 a.m. sitting in her room R15 ' s fingernails had brown/black debris underneath fingernails on both hands even though R15 had a shower on 1/13/205. Again on 1/15/15, at 8:28 a.m. sitting at the dining room breakfast table R15's fingernails had brown/black debris underneath fingernails on both hands. R15's quarterly Minimum Data Set (MDS) dated 12/17/14, identified diagnoses of Parkinson's disease and diabetes. R15 had moderate cognitive impairment with a brief interview for mental status score of 11 and required extensive assist from one staff for activities of daily living, which included dressing, grooming and hygiene needs. R15's current copy of the care plan identified R15 had a self-care deficit related to Parkinson's and required extensive assist of one staff for grooming. The care plan identified R15's diagnosis of diabetes with an intervention of	2 920	Completion Date: February 24th , 2015	

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2 920	Continued From page 12 nursing to provide nail care. During an interview on 1/15/15, at 7:26 a.m. licensed practical nurse (LPN)-D stated nail care was provided on shower days and as needed. R15's shower day is scheduled for Tuesdays (done 1/13/2015). During an interview on 1/15/15, at 7:28 a.m. nursing assistant (NA)-C stated nail care was usually done after showers or after breakfast. NA-C explained if people are diabetic then the foot doctor cuts the nails but the aides clean them. NA-C stated she was trying to get the nail care caught up. NA-C stated R15 had always been cooperative with nail care. During an interview on 1/15/15, at 8:35 a.m. RN-B verified R15 needed assistance with nail care. Facility policy Nursing Care Standards last review date of 5/11 read, "Fingernails and toenails shall be clean and trimmed." The facility provided a copy of a MED-PASS, Inc. procedure (last revised October 2010) Care of Fingernails/Toenails. The procedure read, "The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections., and Nail care includes daily cleaning and regular trimming." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21426	Continued From page 13	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure screening of active TB symptoms and testing was completed upon admission for 4 of 6 residents (R123, R85, R87, R13) and for 4 of 5 newly hired employees (E1, E3, E5, E6) as required for tuberculosis screening. Findings include: Lack of newly admitted residents TB status: R123 was admitted to the facility on 12/11/2014	21426	completion date: February 24th, 2015	2/24/15

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21426	Continued From page 14 and had a symptom screen completed but undated. Further R123 had a documented TST on 12/14/14 with negative results and no documentation was identified for the second TST step. R85 was admitted to the facility on 3/26/2014 and the symptom screen was not completed. In addition R85 received a 2 step TST but the results of both were not documented. R87 was admitted to the facility on on 5/30/2014. The vaccination history for R87 lacked the completion of both the symptom screen and second-step TST. R13 was admitted to the facility on 10/24/14 and the vaccination history lacked evidence of symptom screen and second-step TST. Lack of following Tuberculosis Program for Health Care Workers: E1's start date was documented as 12/30/2014. E1 lacked results of the first TST and no second-step TST was given. E3's start date was documented as 12/11/2014. Neither TST test had documented results. E5's start date was documented as 11/12/2014. Also noted was that the symptom screen was filled out on 1/7/2015. E5 received the first-step TST on 11/12/14 and the second-step on 1/7/15. The symptom screen for E5 was not completed at the time of hire. The first and second TST's were given too far apart and neither TST results were documented. E6's start date was documented as 1/14/2015.	21426		

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21426	Continued From page 15 E6 received the symptom screen and first-step TST on 1/14/15. There was no second step TST administered and the first-step TST lacked documented results. Interview with the director of nursing on 1/15/15 at 11:08 a.m. verified that the facility was not able to find any evidence of TB screening or 2 step TSTs for all current employees. She further added that this recently came to her attention and the facility had started 2 step TST's on all employees, so the facility can get back into compliance. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		2/24/15

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21535	Continued From page 16 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess the effectiveness of Omeprazole to control gastrointestinal reflux disease for 1 of 5 residents (R82) reviewed for unnecessary medications. Findings included: R82's admission Minimum Data Set (MDS) dated 11/10/2014 included a diagnosis of gastro-esophageal reflex disease (GERD) and indicated severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of 2. R82's admission physician orders dated 3/21/14 included, "Omeprazole [belongs to group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach] 20 milligrams (mg) by mouth one tab two times a day one half hour before meals for esophageal reflux." R82's current physician orders provided by the facility on 1/14/15 included Omeprazole 20 mg by mouth one tab two times a day and has received for the past 8 plus months. R82's care plan dated 4/14/14 indicated resident was at risk for alteration in nutritional status related to several factors that included GERD.	21535	Completion date: February 24th, 2015	

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21535	Continued From page 17 Physician's visit note dated 5/22/14, 6/18/14, 10/23/14 and 12/11/14 all dates read the same, " Reflux. Continue Omeprazole." During an interview on 1/15/15, at 10:03 a.m. licensed practical nurse (LPN)-D stated R82 had not complained of gastrointestinal upset and LPN-D was not aware of how GERD was being monitored or assessed to determine if Omeprazole was affective. During an interview on 1/15/15 at 10:05 a.m. registered nurse (RN)-A stated, nursing did not have a specific assessment for GERD and nursing did not assess or monitor if the Omeprazole was affective for treating GERD. RN-A continued to say any information regarding monitoring of Omeprazole probably would be found in the physician's notes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure residents drug regimen is free of unnecessary drugs and monitoring for effectiveness for use of the medications. The Director of Nursing or her designee could educate all appropriate staff. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as	21880		2/24/15

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21880	Continued From page 18 patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	01/15/2015

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21880	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate and promptly resolve a grievance related to missing personal property for 2 of 2 residents (R23, R15) reviewed for personal property. Findings include: R23's quarterly Minimum Data Set dated 11/8/14, identified she was cognitively intact with a brief interview for mental status (BIMS) score of 13. R23's diagnosis included but was not limited to dementia, anxiety and depression. R23's care plan dated 12/7/2006; indicated R23 had impaired cognition related to short term memory loss and history of confusion. On 1/12/15 at 4:43 p.m. R23 reported she had a missing pearl necklace this past summer. R23 reported she informed staff her necklace was missing, stated it didn't seem to matter to them the necklace was missing as nothing was done to locate the necklace. R23's Missing/Broken/Items Tracking form for the pearl necklace was reviewed and revealed R23 reported the necklace missing on 1/29/14, the form was incomplete and an investigation had not been completed for the missing necklace. On 1/14/15 at 10:00 a.m. the licensed social worker (LSW)-A stated R23 reported things missing frequently and staff were usually able to find the missing items or family would state it was not an item R23 had at the facility. LSW-A verified the missing item tracking form for the missing pearl necklace was incomplete and an	21880	Completion Date: February 24th, 2015	

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21880	Continued From page 20	21880		

investigation was not completed. LSW-A verified the facility did not follow the missing item policy and procedure when R23 reported her pearl necklace missing.

On 1/15/15 at 10:29 a.m. the director of nurses stated her expectation was the facility would follow the policy and procedure for missing items when a resident reported a missing item.

On 1/15/15 at 10:44 a.m. the executive director verified the facility did not follow the policy and procedure for R23's missing pearl necklace and stated an investigation should have been completed.

R15's quarterly Minimum Data Set dated 1/3/15, identified she was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 also R15's diagnosis included but was not limited to Parkinson's disease and diabetes.
R15's care plan dated 8/10/2013; indicated R15 had impaired cognition due to intermittent changes to BIMS scores, intermittent confusion at times requiring verbal cues and times.
On 1/13/15, at 8:45 a.m. R15 reported she had been missing $33.00 out of her dresser some time ago.
R15 reported she had informed staff of her missing money after she had noticed it missing, stated they never got back to me about it and didn't get the money back.
R15's Missing/Broken/Items Tracking form for the $33.00 was reviewed and revealed R15 reported the money missing on 12/4/13, the form was incomplete and an investigation had not been completed for missing money.
On 01/14/15 at 8:49 a.m. the licensed social worker (LSW)-A stated R15 was severely

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21880	Continued From page 21 cognitively impaired at the time the money was reported missing and the administrator determined that no further action needed to take place because of the mental status vs. foul play. LSW-A verified a full investigation was not completed for that reason. The Missing Item Policy dated 6/4/13 read, "Procedure: 1. At the time any item is reported missing a search will be done. The person that was told of the missing item will fill out a missing item report sheet that is located at each nurses station and give missing item form to Social services. 2. Resident Service Director will review missing item sheet and investigate. 3. Resident Service Director will contact the resident and their family of missing item and reassure them that a search is being conducted. 4. Resident Service Director will also contact resident and family of outcome of investigation." SUGGESTED METHOD OF CORRECTION: The director of social services or administrator could educate all appropriate staff members on the process of reporting missing personal items. The director of social services or administrator could develop monitoring systems to ensure ongoing compliance and follow up ion missing items is being done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in	21942		2/24/15

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21942	Continued From page 22 participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to establish a family council during the past calendar year. Findings include: During interview with licensed social worker (LSW)-A on 1/3/15, at 12:55 p.m. indicated there had been no active family council in the past year and verified that there had been no attempts by the facility to establish a family council during the past year. SUGGESTED METHOD OF CORRECTION: The individual responsible for the annual attempt to establish a family council/group would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21942	Completion Date; February 24th, 2015	