DEPARTMENT OF HEAD						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: WMOJ
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00394
1. MEDICARE/MEDICAID PROV	IDER NO.	3. NAME AND AI (L3) ST MARKS				4. TYPE OF ACTION: $\underline{7}(L8)$
(L1) <b>245369</b> 2.STATE VENDOR OR MEDICAL	ID NO	(L4) <b>400 - 15TH</b>			۰	1. Initial 2. Recertification
(L2) 055842700	ID NO.	(L5) AUSTIN, M		11101201	(L6) <b>55912</b>	3. Termination     4. CHOW       5. Validation     6. Complaint
5. EFFECTIVE DATE CHANGE	OF OWNERSHIP			ODV	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	05 HHA	0 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
	3/02/2015 (L34)	02 SNF/NF/Dual	05 IIIA 06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/II		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
2 AOA 3 Oth	er					
11LTC PERIOD OF CERTIFICAT	TION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia				The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	<b>61</b> (L18)		cceptable POC		4. 7-Day RN (Rural SN	
					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>61</b> (L17)		npliance with Prog ents and/or Appli		* Code: A	(L12)
		riequiteri	ents una or rippi		A	()
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
61						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Nederho	off, Unit Supervis	<u>or 0</u>	03/02/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 03/16/2015 (L20)
I	PART II - TO BE	COMPLETED I	BY HCFA RF	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIG	BILITY	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2572)
			HTS ACT:		2. Ownership/Contro	ol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible 2. Facility is not Elig	-				3. Both of the Above	······
2. Facility is not Eng	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	JENT 2	4. LTC AGREEN	/ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY _0	
12/01/1986	BEGINNING	TDATE	ENDING DA	IE	01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VESANCTIONS	(L23)		03-Risk of Involuntary Termination	-
25. LIC EXTENSION DATE.		of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)	02/25/2015		(L33)	DETERMINATION APP	ROVAL



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,

Kumala Fiske Downing

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



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 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,

Kumalu Fiske Downing

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

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245369	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/2/2015
Name of Facility		Street Address, City, State, Zip Code	
ST MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWI AUSTIN, MN 55912	EST

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. #	483.10(f)(2)		Correction Completed 02/24/2015	ID Prefix Reg. #	483.20(b)(1)		Correction Completed 02/24/2015		ID Prefix Reg. # LSC	483.20(k)(3)(i	i)	Correction Completed 02/24/2015
ID Prefix Reg. #	F0309 483.25		Correction Completed 02/24/2015	ID Prefix Reg. #	F0312 483.25(a)(3)		Correction Completed 02/24/2015		ID Prefix Reg. #			Correction Completed 02/24/2015
Reg. #			Correction Completed	Reg. #			Correction Completed		Reg. #			
Reg. #							Correction Completed		<b>–</b> "			
Reg. #			Correction Completed						D.a. #			
Reviewed I	By F	leviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen Reviewed I CMS RO		<u>GPN/kf</u> Reviewed		03/02/20 Date:	15 Signature	of Sur		) <u>160</u>			Date:	03/02/2015
Followup t	to Survey Comp 1/15/2		:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245369	(Y2) Multiple Construction A. Building B. Wing 01 - M	AIN BUILDING 01	(Y3) Date of Revisit 2/13/2015
Name of Facility		Street Address, City, State, Zip Code	
ST MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWI AUSTIN, MN 55912	EST

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
		(	Correction				Correction					Correction
ID Prefix			Completed 02/11/2015	ID Prefix			Completed 01/19/2015		ID Prefix			Completed 02/04/2015
•	NFPA 101			•	NFPA 101				0	NFPA 101		
LSC	K0011			LSC	K0050				LSC	K0062		
			Correction				Correction					Correction
ID Prefix			Completed 02/02/2015	ID Prefix			Completed 02/12/2015		ID Prefix			Completed 01/31/2015
Reg. #	NFPA 101			Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0071			LSC	K0076				LSC	K0144		
			Correction				Correction					Correction
			Completed	ID Profix			Completed		ID Profix			Completed
									- <i>"</i>			
Reg. # LSC				Reg. # LSC					Reg. # LSC			
			Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					Reg. #			
LSC												
		(	Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #												
				LSC					LSC			
Reviewed I	Зу R	eviewed	Ву	Date:	Signa	ature of Sur	veyor:				Date:	
State Agen	су	PS/kfd		03/02/2	015		25	5822				02/13/2015
Reviewed I CMS RO	Зу R	eviewed	Ву	Date:	Signa	ature of Sur	veyor:				Date:	
Followup t	o Survey Comp 1/15/20		:							Summary of the Facility?	YES	NO
				l	_							-

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245369	(Y2) Multiple Cons A. Building B. Wing	13 ADDITION	(Y3) Date of Revisit 2/13/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
ST	MARKS LUTHERAN HOME		400 - 15TH AVENUE SOUTHWE AUSTIN, MN 55912	EST

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)	ltem		(Y5)	Date
ID Prefix		C	Correction Completed 01/19/2015	ID Prefix			Correction Completed 01/31/2015		ID Prefix			Correction Completed
-	NFPA 101			-	NFPA 101				Reg. #			
LSC	K0050			LSC	K0144				LSC			
		C	Correction				Correction					Correction
		C	Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					Reg. #			
-									LSC			
		C	Correction				Correction					Correction
ID Prefix			Completed	ID Drofiv			Completed		ID Drofiv			Completed
Reg. # LSC				Reg. # LSC					Reg. # LSC			
		C	Correction				Correction					Correction
ID Prefix		C	Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					_			
LSC				LSC					LSC			
ID Prefix		C	Correction Completed	ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. #				Rea. #					Pog #			
LSC		_		LSC					LSC			
Reviewed E	By Review	wed B	Ву	Date:	Signature	of Surv	veyor:				Date:	
State Agen	cy	PS/	/kfd	03/02/20	15		258	22				02/13/2015
Reviewed E CMS RO	Sy Review	wed I	Ву	Date:	Signature of	of Surv	veyor:				Date:	
Followup t	o Survey Completed 1/15/2015	d on:			Check for any Uncorrected					Summary of the Facility?	YES	NO



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,

Kumalu Fiske Downing

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

### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00394	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/2/2015
Name	e of Facility		Street Address, City, State, Zip Code	
ST MARKS LUTHERAN HOME			400 - 15TH AVENUE SOUTHWE AUSTIN, MN 55912	EST

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	(Y	5) Date	(Y4) Item	(Y5) Date
ID Prefix	20540	Correction Completed 02/24/2015	ID Prefix	20565	Correction Completed 02/24/2015	ID Prefix	Correctio Complete 20830 02/24/20
	MN Rule 4658.040			MN Rule 4658.0405 S			MN Rule 4658.0520 Subp.
ID Prefix Reg. # LSC	20920 MN Rule 4658.052	Correction Completed 02/24/2015 25 Subp.		21426 MN St. Statute 144A.0		Reg. #	Correctio Complete 21535 02/24/20 MN Rule4658.1315 Subp.1
	21880 MN St. Statute 14			21942 MN St. Statute 144A.1		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #	Correctio Complete
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	
Reviewed E State Agen Reviewed E CMS RO	cy GP	iewed By N/kfd iewed By	Date: 03/02/201 Date:	Signature of St	101	.60	Date: 03/02/201 Date:
Followup t	o Survey Complet 1/15/201 M: REVISIT REPO	5		Check for any Unc Uncorrected Def Page 1 of 1			

DEPARTMENT OF HEALTH A						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: WMOJ
					TE SURVEY AGENCY	Facility ID: 00394
1. MEDICARE/MEDICAID PROVIDER N (L1) 245369	0.	3. NAME AND AI (L3) ST MARKS				4. TYPE OF ACTION: $2(L8)$
2.STATE VENDOR OR MEDICAID NO.		(L4) <b>400 - 15TH</b>			,	1. Initial2. Recertification3. Termination4. CHOW
(L2) <b>055842700</b>		(L5) AUSTIN, M	N		(L6) <b>55912</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN	IERSHIP	7. PROVIDER/SU	JPPLIER CATEO	FORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 01/15/201	15 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	Y IS CERTIFIED	AS:		·
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
	(1 (1 10)	•	e Based On:		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director
12. Total Facility Beds	<b>61</b> (L18)	1. A	cceptable POC		5. Life Safety Code	F) <u>8</u> . Patient Room Size 9. Beds/Room
13.Total Certified Beds	<b>61</b> (L17)	X B. Not in Cor	npliance with Prog ents and/or Appli	gram		(L12)
		Kequitein	ients and/or Appn	ieu warvers.	B.	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
61	(1.20)	(1.42)	(1.12)			
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
			2/10/2015	-		
<u>Kyla Einertson, HFE NE I</u>	I		02/10/2015	(L19)	Kamala Fiske-Downing, E	Enforcement Specialist 02/23/2015 (L20)
PART	II - TO BE	COMPLETED	BY HCFA RH	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY		20. COM	IPLIANCE WITI	H CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)
1. Facility is Eligible to Partic	inate	RIGI	HTS ACT:		<ol> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	1				5. Bour of the Roove	·
	(L21)					
22. ORIGINAL DATE 23	. LTC AGREE	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ΤЕ	VOLUNTARY 00	INVOLUNTARY
12/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	of Functo informing content
25. LTC EXTENSION DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:	( <b>a</b> 1 1)		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind St	uspension Date:	(L44)			00-ACTIVE
			(L45)			
28. TERMINATION DATE:	29	). INTERMEDIARY			30. REMARKS	
	_,	03001				
	(L28)	05001		(L31)		
	、 /			/		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL



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:

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

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

<u>Remedies</u> - 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;

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - 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. St Marks Lutheran Home January 29, 2015 Page 4

## 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

St Marks Lutheran Home January 29, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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.

St Marks Lutheran Home January 29, 2015 Page 6

Sincerely,

Kumalu Fiske Downing

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

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OM	B NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		: CONSTRUCTION (X		E SURVEY PLETED
		245369	B. WING _			01/-	15/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	<b>(S LUTHERAN HOME</b>			40	0 - 15TH AVENUE SOUTHWEST		
SIWAN				Al	JSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 00	00			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 nic submission of the POC will ion of compliance.					
F 166 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TO PROMPT EFFORTS TO NCES	F 1(	66			2/24/15
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior					
	by: Based on interview facility failed to inve grievance related to	NT is not met as evidenced y and document review, the stigate and promptly resolve a o missing personal property for 23, R15) reviewed for personal			<ul> <li>F 166</li> <li>1. Corrective Action:</li> <li>A. Resident R23 was determined th family took the necklace home 2 year ago.</li> <li>B. Resident R 15. Family contacted family stated that they are not concertioned that they are not concertioned family stated that they are not concertioned family stated that they are not concerting the stated that they are not concerting the stated that the</li></ul>	rs I and	
	identified she was of interview for mental	imum Data Set dated 11/8/14, cognitively intact with a brief I status (BIMS) score of 13. Iuded but was not limited to ind depression.			<ol> <li>Correction action as it applies to residents:</li> <li>A. It is the policy and procedure of S Mark s that missing items tracking ferrors</li> </ol>	St. forms	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						02/06/2015

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

program participation.

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

PRINTED: 02/09/2015

		AND HUMAN SERVICES				FORM	02/09/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245369	B. WING			<b>01</b> / <sup>.</sup>	15/2015
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	1			00 - 15TH AVENUE SOUTHWEST .USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	R23's care plan dat had impaired cogni memory loss and h On 1/12/15 at 4:43 missing pearl neckl R23 reported she ir was missing, stated them the necklace done to locate the r R23's Missing/Brok pearl necklace was reported the neckla form was incomplet been completed for On 1/14/15 at 10:00 worker (LSW)-A sta missing frequently a find the missing iter not an item R23 ha the missing iter tra pearl necklace was investigation was n the facility did not for and procedure when necklace missing. On 1/15/15 at 10:29 stated her expectat follow the policy and when a resident rep On 1/15/15 at 10:44 verified the facility of procedure for R23's	ted 12/7/2006; indicated R23 tion related to short term istory of confusion. p.m. R23 reported she had a ace this past summer. formed staff her necklace d it didn't seem to matter to was missing as nothing was necklace. en/Items Tracking form for the reviewed and revealed R23 ice missing on 1/29/14, the te and an investigation had not the missing necklace. D a.m. the licensed social ated R23 reported things and staff were usually able to ms or family would state it was d at the facility. LSW-A verified acking form for the missing	F 1	166	<ul> <li>will be completed and documented 5 days of discovery.</li> <li>3. Date of completion: February 2 2015</li> <li>4. Reoccurrence will be prevented A. Staff education and training on and procedure of missing items will completed on Feb. 12th, 2015</li> <li>B. Audits will be completed month results shared at Q/A.</li> <li>5. Correction will be monitored by A. Administrator or designee</li> <li>B. Q/A committee will review the a results on a quarterly basis and produrections as needed.</li> </ul>	24, by: policy be ly and : udit	

If continuation sheet Page 2 of 16

DEPART CENTE	FORM APPROVED MB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING			<b>01</b> / <sup>.</sup>	15/2015
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		-		4	00 - 15TH AVENUE SOUTHWEST		
SI WAR	KS LUTHERAN HOME	-		A	AUSTIN, MN 55912		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	identified she was r impaired with a brie (BIMS) score of 11 but was not limited diabetes. R15's care plan dat had impaired cogni changes to BIMS set times requiring vert On 1/13/15, at 8:45 been missing \$33.0 time ago. R15 reported she h missing money after stated they never g didn't get the mone R15's Missing/Brok \$33.00 was reviewed the money missing incomplete and an completed for miss On 01/14/15 at 8:45 worker (LSW)-A sta cognitively impaired reported missing ar determined that no place because of th LSW-A verified a fut completed for that in The Missing Item P "Procedure: 1. At the missing a search w was told of the miss item report sheet th station and give miss	imum Data Set dated 1/3/15, noderately cognitively of interview for mental status also R15's diagnosis included to Parkinson's disease and ated 8/10/2013; indicated R15 tion due to intermittent cores, intermittent confusion at bal cues and times. 5 a.m. R15 reported she had 00 out of her dresser some ad informed staff of her or she had noticed it missing, ot back to me about it and y back. en/Items Tracking form for the ed and revealed R15 reported on 12/4/13, the form was investigation had not been ing money. 9 a.m. the licensed social ated R15 was severely d at the time the money was nd the administrator further action needed to take he mental status vs. foul play. Il investigation was not	F 1	166			

If continuation sheet Page 3 of 16

	-	AND HUMAN SERVICES			FORM	02/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245369	B. WING		01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	:		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 166 F 272 SS=D	Service Director wil family of missing ite search is being con Director will also co outcome of investig	I contact the resident and their em and reassure them that a iducted. 4. Resident Service intact resident and family of jation."	F 166 F 272			2/24/15
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's				
	resident assessmer by the State. The a least the following:	sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information;				
	Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses	and procedures; and procedures; and procedures; summary information regarding ssment performed on the care the completion of the Minimum				

Facility ID: 00394

If continuation sheet Page 4 of 16

		AND HUMAN SERVICES			F	ORM /	02/09/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:	,	E SURVEY PLETED	
		245369	B. WING	i		01/1	5/2015	
NAME OF I	PROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LUTHERAN HOME	1	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 272		ge 4 participation in assessment.	F	272				
	by: Based on observative review the facility fat assess the need for services and need 1 of 1 resident (R82 issues.	NT is not met as evidenced tion, interview, and document ailed to comprehensively r ongoing nursing home for mental health services for 2) with identified mental health			<ul> <li>F272</li> <li>1. Corrective Action:</li> <li>A. Resident R 82 has been assigned county worker.</li> <li>B. MDS coding has been corrected</li> <li>C. The county will assign a mental he case manager to evaluate and follow.</li> </ul>	ealth		
	health diagnosis ar time of the admissi comprehensive ass R82's admission M 3/28/14 included di psychotic disorder, drug abuse, and his (TBI)) and indicated with a Brief Intervie (BIMS) of 5. Also w another nursing fac Admission MDS dat MDS dated 5/18/14 of mental health iss 6/24/14, and the qu R82 had a serious	inimum Data Set (MDS) dated agnoses of anxiety disorder, neurotic disorders, history of story of traumatic brain injury d severe cognitive impairment w for Mental Status Score vas admitted on 3/21/14 from			<ol> <li>Corrective Action as it applies to cresidents:         <ul> <li>A. St. Mark s Policy and Procedure PAS/PASRR screening will be followe</li> <li>Date of Completion: February 24 2015. Reoccurrence will be preventiby:</li></ul></li></ol>	e for ed. Ith, ted		
	Preadmission Scre (PASRR) dated 2/2	ening and Resident Review 0/14 and failed to assess R82 nursing home care and need			<ul> <li>A. DON or designee</li> <li>B. Q/A committee will review the auc results on a quarterly basis and provid</li> </ul>			

Facility ID: 00394

If continuation sheet Page 5 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093							
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245369	B. WING		<b>01</b> / <sup>.</sup>	15/2015	
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LUTHERAN HOME	1		100 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 272 F 282 SS=D	for specialized serv make a referral to the The PASRR dated a documented mental secondary to TBI, re- home placement for therapy and planner after completion of "Admission is appro- following inpatient of less than 30 days s authorization., and a approved: follow up needed beyond the During an interview licensed social work admission MDS did for R82. 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observation review, the facility fa plan was followed for concerns, related to bruises for 1 of 3 re- non-pressure related the facility failed followed for concerns and the facility failed followed for concerns and the facility failed followed for concerns and the facility failed followed for the facility failed followed for concerns and the facility failed followe	<ul> <li>ices. The facility also failed to he local contact agency.</li> <li>2/20/14 indicated R82 had a lillness; psychotic disorder equired short term nursing r physical and occupational d to return to assisted living therapy. The PASRR read, oved: convalescent care care for the same condition, tay and includes MD written admission has been will be required if extension is specified time limit. " on 1/15/15, at 9:18 a.m. ker (LSW)-A verified not address a mental illness</li> <li>RVICES BY QUALIFIED ARE PLAN</li> <li>led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to ensure the written care or monitoring of skin o identifying and reporting sidents (R61) reviewed for ed skin conditions, in addition ow the written care plan to r 1 of 3 resident (R15)</li> </ul>	F 272	further direction as needed.	lked to o follow	2/24/15	

Event ID: WMOJ11

Facility ID: 00394

If continuation sheet Page 6 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-0391         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245369       B. WING       01/15/2015         ST MARKS LUTHERAN HOME       STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912       01/15/2015         (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)       COMPLETION DATE         F 282       Continued From page 6       F 282       E       Corrective action as it applies to other residents: A. Will review Policy and procedure for         Lack of monitoring for bruising and timely notification of licensed staff for resident with blood       A. Will review Policy and procedure for       A. Will review Policy and procedure for	DEPARTMENT OF HEALTH AND HUMAN SERVICES							
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETED         245369       B. WING       01/15/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       01/15/2015         ST MARKS LUTHERAN HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       400 - 15TH AVENUE SOUTHWEST         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       COMPLETION SHOULD BE         TAG       CONTINUED FROM DATION)       F282       Continued From page 6       F 282         Findings Include:       Lack of monitoring for bruising and timely notification of licensed staff for resident with blood       2. Corrective action as it applies to other residents:         A. Will review Policy and procedure for       A. Will review Policy and procedure for				(X2) MULTI				
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ST MARKS LUTHERAN HOME       400 - 15TH AVENUE SOUTHWEST         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)         F 282       Continued From page 6         Findings Include:       2.         Lack of monitoring for bruising and timely       A. Will review Policy and procedure for	-							
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ST MARKS LUTHERAN HOME       400 - 15TH AVENUE SOUTHWEST         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)         F 282       Continued From page 6         Findings Include:       2.         Lack of monitoring for bruising and timely       A. Will review Policy and procedure for			0.17000					
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 282       Continued From page 6       F 282         Findings Include:       2. Corrective action as it applies to other residents:       2. Corrective action as it applies to other residents:			245369	B. WING _		01/1	5/2015	
ST MARKS LUTHERAN HOME         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 282       Continued From page 6       F 282       Findings Include:       2.       Corrective action as it applies to other residents:       2.       Corrective action as it applies to other residents:       2.       Corrective action as it applies to other residents:								
PREFix TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFix TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         F 282       Continued From page 6       F 282       F 282       Image: Control of the second secon	ST MAR	(S LUTHERAN HOME						
TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         F 282       Continued From page 6       F 282       Findings Include:       2. Corrective action as it applies to other residents:       2. Corrective action as it applies to other residents:       0								
F 282       Continued From page 6       F 282         Findings Include:       2. Corrective action as it applies to other residents:         Lack of monitoring for bruising and timely notification of licensed staff for resident with blood       A. Will review Policy and procedure for					CROSS-REFERENCED TO THE APPROPR			
Findings Include:       2. Corrective action as it applies to other residents:         Lack of monitoring for bruising and timely notification of licensed staff for resident with blood       A. Will review Policy and procedure for					DEFICIENCY)			
Findings Include:       2. Corrective action as it applies to other residents:         Lack of monitoring for bruising and timely notification of licensed staff for resident with blood       A. Will review Policy and procedure for	F 282	Continued From pa	ae 6	F 28	22			
Lack of monitoring for bruising and timely notification of licensed staff for resident with blood2. Corrective action as it applies to other residents: A. Will review Policy and procedure for		oontinuou roin pu	900	1 20	<i>'</i>			
Lack of monitoring for bruising and timely notification of licensed staff for resident with bloodresidents: A. Will review Policy and procedure for		Findings Include:						
notification of licensed staff for resident with blood A. Will review Policy and procedure for		Lack of monitoring	for bruising and timely			) other		
		notification of licens	sed staff for resident with blood		A. Will review Policy and procedur			
		thinner medication:			all residents at the POC meeting to	be		
R61 was observed on 1/13/2015 at 8:55 a.m. toheld Feb. 12th, 2015.B. All staff will be educated on		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 monitoring nails and report need for nail		have a bruise on the	e back of his right hand by his		monitoring nails and report need for			
wrist with no documentation of the bruise being found until the staff was informed of the bruise by Feb 12th, 2015.						eting		
found until the staff was informed of the bruise by surveyor on 1/14/15.Feb 12th, 2015.C. Nursing staff will be educated on						n		
monitoring for skin changes per St.		-			monitoring for skin changes per St.			
R61's significant change in status Minimum Data Set (MDS) dated 11-8-14, identified diagnoses of Mark s Skin Assessment Policy at POC meeting Feb. 12th, 2015.						POC		
heart failure, post-traumatic stress disorder and								
diabetes mellitus. R61 had severe cognitive		diabetes mellitus. R	61 had severe cognitive					
impairment with a brief interview for mental status 3. Date of Completion: February 24th score (BIMS) of three and required extensive 2015.						24th		
score (BIMS) of three and required extensive 2015. assist from two staff for activities of daily living,					2015.			
which included mobility and transfers.								
4.Reoccurrence will be prevented by:R61's plan of care dated 10/28/13 read,A.Audits will be completed weekly and		B61's plan of care of	1atod 10/28/13 road					
"Resident receives Coumadin results shared at Q/A.						anu		
[anticoagulation-blood thinner]." Interventions B. All staff will be educated on		. 0	-					
included "Monitor for signs and symptoms of bleeding." monitoring nails and report need for nail care to nursing staff at the POC meeting			or signs and symptoms of					
Feb 12th, 2015.		bleeding.				eung		
On 1/15/15 at 7:25 a.m. nursing assistant (NA)-A C. Nursing staff will be educated on					C. Nursing staff will be educated o	n		
stated she monitored resident skin for bruisingmonitoring for skin changes per St.when she provided daily cares and reported anyMark s Skin Assessment Policy at POC						POC		
bruises to the nurse. NA-A stated on a resident's meeting Feb. 12th, 2015.								
bath day the nursing assistant and the nurse		bath day the nursing	g assistant and the nurse					
completed skin inspections. NA-A stated she noticed the bruise on the back of R23's right hand 5. Correction will be monitored by:					5 Correction will be manitored by:			
on 1/12/15 in the morning when she checked A. DON or designee								
R61's blood sugar. NA-A stated she did not B. Q/A committee will review the audit		R61's blood sugar.	NA-A stated she did not		B. Q/A committee will review the a			
report the bruise on his hand to the nurse and stated she thought staff was already aware of the further direction as needed.						vide		

Facility ID: 00394

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	COM	IPLETED
		245369	B. WING			01/ <sup>.</sup>	15/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	-		4	400 - 15TH AVENUE SOUTHWEST		
		•		ŀ	AUSTIN, MN 55912		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 282	Continued From pa	.ge 7	F 2	282	1 -		
	bruise.						
	Deview of the pure						
		e progress note completed by 5 read, "This nurse notified of					
		RT [right] hand. Resident has					
		le) to RT [right] hand on top of					
		nb and first finger. Charge					
		e is irregular is irregular shape					
	and measures 5 x 4	4 cm [centimeters]"					
	On 1/15/15 10:33 a	.m. the director of nursing					
		expected staff to check					
	resident skin during	cares daily and report any					
	skin issues to the c	harge nurse. The DON stated					
		en measure and note color of					
		v the resident regarding the					
		e an incident report. The DON did not follow R61's care plan					
		sidents skin for bleeding.					
	Lack of nail care for	r resident dependent on staff					
	to meet activities of	daily living skills (ADLs):					
		on 01/13/15, at 8:52 a.m.					
		R15's fingernails had					
	both hands.	underneath fingernails on					
		on 1/14/15, at 2:30 p.m. sitting					
		fingernails had brown/black					
		fingernails on both hands.					
		at 8:28 a.m. sitting at the dining					
		le. R15's fingernails had					
	both hands.	underneath fingernails on					
		imum Data Set (MDS) dated					
		diagnoses of Parkinson's					
		es. R15 had moderate					
		nt with a brief interview for					
		of 11 and required extensive					
		ff for activities of daily living,					
	which included dres	sing and nyglene.					

If continuation sheet Page 8 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/09/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245369	B. WING			01/	15/2015
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST MARK	(S LUTHERAN HOME	1			00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	had a self-care defirequired extensive a grooming. The care diagnosis of diabete nursing to provide r During an interview licensed practical m was provided on sh R15's shower day is During an interview nursing assistant (N usually done after s NA-C explained if p foot doctor cuts the them. NA-C stated care caught up. NA been cooperative w During an interview RN-B verified reside extensive assist wit extensive assist wit Facility policy Nursi date of 5/11 read, "I be clean and trimm. The facility provided procedure (last revi Fingernails/Toenails procedure provided should be recorded date and time that r title of individual wh and The condition of	of the care plan identified R15 cit related to Parkinson's and assist of one staff for plan identified R15's es with an intervention of nail care. on 1/15/15, at 7:26 a.m. urse (LPN)-D stated nail care ower days and as needed. s scheduled for Tuesdays. on 1/15/15, at 7:28 a.m. IA)-C stated nail care was howers or after breakfast. eople are diabetic then the nails but the aides clean she was trying to get the nail -C stated R15 had always ith nail care. on 1/15/15, at 8:35 a.m. ents that are care planned h hygiene included needing h nail care. ng Care Standards last review Fingernails and toenails shall	F 2	82			
F 309	bed" 483.25 PROVIDE C	ARE/SERVICES FOR	F 3	,09			2/24/15

Facility ID: 00394

If continuation sheet Page 9 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM. CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0938-0391 SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED	
		245369	B. WING			<b>01</b> /1	5/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 - 15TH AVENUE SOUTHWEST			
ST MAR	<b>(S LUTHERAN HOME</b>				USTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309 SS=D	Continued From pa HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat review, the facility fa 3 residents (R61) re related skin condition Findings Include: R61 was observed have a bruise on the wrist with no docum found until the staff surveyor on 1/14/15	ge 9 EING receive and the facility must ary care and services to attain hest practicable physical, social well-being, in e comprehensive assessment NT is not met as evidenced ion, interview and document ailed to identify bruises for 1 of eviewed for non-pressure ons.	F 3			esment ace. o other re for be	DATE	
	heart failure, post-tr diabetes mellitus. R impairment with a b score (BIMS) of thre assist from two staf which included mob R61's plan of care of	raumatic stress disorder and 61 had severe cognitive brief interview for mental status ee and required extensive f for activities of daily living,			<ul> <li>Mark s Skin Assessment Policy at meeting Feb. 12th, 2015.</li> <li>3. Date of Completion: February 2015.</li> </ul>	POC		
		for signs and symptoms of			<ul><li>4. Reoccurrence will be prevented</li><li>A. Audits will be completed weekly</li></ul>			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245369	B. WING			01/ <sup>-</sup>	15/2015
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	1			00 - 15TH AVENUE SOUTHWEST JUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	skin audits were rev documentation in re back his right hand. On 12/17/14 at 2:55 (NA)-D stated she r bruising when provi any bruises to the r On 1/15/15 at 7:25 stated she monitore when she provided bruises to the nurse bath day the nursin completed skin insp noticed the bruise of hand on 1/12/15 in checked R61 ' s blo did not report the br and stated she thou the bruise. On 1/14/15 at 1:49 verified there was n the medical record R61 ' s right hand a had not been comp Review of the nurse RN-A dated 1/14/15	5 progress notes and weekly viewed and there was no egards to the bruise on the 5 p.m. nursing assistant nonitored resident skin for ding cares daily and reported nurse right away. a.m. nursing assistant (NA)-A ed resident skin for bruising daily cares and reported any e. NA-A stated on a resident ' s g assistant and the nurse bections. NA-A stated she on the back of R23 ' s right the morning when she bod sugar. NA-A stated she ruise on his hand to the nurse ught staff was already aware of p.m. registered nurse (RN)-A to documentation completed in for the bruise on the back of nd verified an incident report leted. e progress note completed by 5 read, " This nurse notified of s RT [right] hand. Resident	F 3	809	DEFICIENCY) results shared at Q/A. B. Nursing staff will be educated of monitoring for skin changes per St. Mark s Skin Assessment Policy at meeting Feb. 12th, 2015. 5. Correction will be monitored by A. DON or designee B. Q/A committee will review the results on a quarterly basis and pro- further direction as needed.	POC : audit	
	bruise to resident ' a has a bruise (dark p top of hand betwee Charge nurse awar						

Facility ID: 00394

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	: 02/09/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3) DAT	TE SURVEY MPLETED
		245369	B. WING		/15/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ST MARK	(S LUTHERAN HOME			100 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 F 312 SS=D	(DON) stated she e resident skin during skin issues to the cl the nurse should the the bruise, interview bruise and complete verified the facility of for monitoring of res policy for monitoring conditions was requ 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives	m. the director of nursing xpected staff to check cares daily and report any harge nurse. The DON stated en measure and note color of the resident regarding the e an incident report. The DON id not follow R61 's care plan sidents skin for bleeding. A g of non-pressure related skin lested and not provided. ARE PROVIDED FOR	F 309 F 312		2/24/15
	by: Based on observat review, the facility fa of 1 resident (R15) assistance to maint needs. Findings included: R15 was observed sitting in her room. brown/black debris both hands. Again o in her room R15 ' s debris underneath f though R15 had a s 1/15/15, at 8:28 a.m	IT is not met as evidenced ion, interview, and document ailed to provide nail care for 1 who required extensive staff ain grooming and hygiene on 01/13/15, at 8:52 a.m. R15's fingernails had underneath fingernails on on 1/14/15, at 8:30 a.m. sitting fingernails had brown/black ingernails on both hands even hower on 1/13/205. Again on a. sitting at the dining room 's fingernails had brown/black		<ul> <li>F312</li> <li>Corrective Action:</li> <li>A. Resident R15 received nail care promptly.</li> <li>B. Staff educated on proper nail care and St. Mark s Policy and Procedure reviewed.</li> <li>Corrective action as it applies to other residents: <ul> <li>A. Will review Policy and procedure for all residents at the POC meeting to be held Feb. 12th, 2015.</li> <li>B. All staff will be educated on monitoring</li> </ul> </li> </ul>	

Facility ID: 00394

If continuation sheet Page 12 of 16

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED	
		245369	B. WING		01/	15/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LUTHERAN HOME	E		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 312	debris underneath R15's quarterly Min 12/17/14, identified disease and diabet cognitive impairme mental status score assist from one sta which included drea needs. R15's current copy had a self-care defi required extensive grooming. The care diagnosis of diabet nursing to provide r During an interview licensed practical n was provided on sh R15's shower day i (done 1/13/2015). During an interview nursing assistant (N usually done after s NA-C explained if p foot doctor cuts the them. NA-C stated care caught up. NA been cooperative w During an interview RN-B verified R15 care. Facility policy Nursi date of 5/11 read, " be clean and trimm The facility provide procedure (last rev Fingernails/Toenails purpose of this provide	fingernails on both hands. imum Data Set (MDS) dated diagnoses of Parkinson's es. R15 had moderate nt with a brief interview for e of 11 and required extensive ff for activities of daily living, ssing, grooming and hygiene of the care plan identified R15 icit related to Parkinson's and assist of one staff for e plan identified R15's es with an intervention of hail care. r on 1/15/15, at 7:26 a.m. urse (LPN)-D stated nail care hower days and as needed. s scheduled for Tuesdays r on 1/15/15, at 7:28 a.m. NA)-C stated nail care was showers or after breakfast. beople are diabetic then the e nails but the aides clean she was trying to get the nail -C stated R15 had always r on 1/15/15, at 8:35 a.m. needed assistance with nail ang Care Standards last review Fingernails and toenails shall	F 31	<ul> <li>2 nails and report need for nail care nursing staff at the POC meeting 12th, 2015.</li> <li>3. Date of Completion: Februa 2015.</li> <li>4. Reoccurrence will be prevent</li> <li>A. Audits will be completed weel results shared at Q/A.</li> <li>B. All staff will be educated on monitoring nails and report need care to nursing staff at the POC meet 12th, 2015.</li> <li>5. Correction will be monitored to A. DON or designee</li> <li>B. Q/A committee will review the results on a quarterly basis and p further direction as needed.</li> </ul>	Feb ary 24th, ed by: kly and for nail neeting by: e audit		

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DEPART CENTER		FORM	APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245369	B. WING _		01/ <sup>-</sup>	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	1		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		CROSS-REFERENCED TO THE APPROPR	JLD BE COMPLETIO		
F 312 F 329	infections., and Nai and regular trimmin	care includes daily cleaning	F 31 F 32			2/24/15
F 329 SS=D	UNNECESSARY D		Г 32	29		2/24/13
	unnecessary drugs. drug when used in o duplicate therapy); o without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug ry to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically				
	drugs. This REQUIREMEN by: Based on interview facility failed to asse Omeprazole to cont	An effort to discontinue these NT is not met as evidenced and document review, the ess the effectiveness of trol gastrointestinal reflux esidents (R82) reviewed for ations.		F329 1. Corrective Action: A. Resident R82 pharmacist const completed a med review 1/22/2015		

Facility ID: 00394

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/09/2015 APPROVED 0938-0391
				(X3) DATE SURVEY COMPLETED		
245369			B. WING _		01/15/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	S LUTHERAN HOME			400 - 15TH AVENUE SOUTHWEST		
		-		AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 14	F 32	9 Omeprazole (recommendation was	to	
		nimum Data Set (MDS) dated		continue). B. Medical Director reviewed need Omeprazole for Dx. of GERD.	l for	
	indicated severe co Interview for Menta R82's admission phincluded, "Omeprazicalled proton pump amount of acid protom milligrams (mg) by	reflex disease (GERD) and gnitive impairment with a Brief I Status Score (BIMS) of 2. hysician orders dated 3/21/14 cole [belongs to group of drugs inhibitors. It decreases the duced in the stomach] 20 mouth one tab two times a day		<ol> <li>Corrective action as it applies to residents:</li> <li>A. Continued service by consultan pharmacist on a monthly basis</li> <li>B. Continue review by Medical direction of the every 60 days .</li> </ol>	t	
	one half hour before "R82's current physi facility on 1/14/15 ir mouth one tab two for the past 8 plus r R82's care plan dat was at risk for altera related to several fa Physician's visit not 10/23/14 and 12/11. Reflux. Continue Of During an interview licensed practical n not complained of g LPN-D was not awa monitored or asses Omeprazole was af During an interview registered nurse (R have a specific asso	e meals for esophageal reflux. cian orders provided by the included Omeprazole 20 mg by times a day and has received nonths. ed 4/14/14 indicated resident ation in nutritional status actors that included GERD. e dated 5/22/14, 6/18/14, /14 all dates read the same, " meprazole." on 1/15/15, at 10:03 a.m. urse (LPN)-D stated R82 had gastrointestinal upset and are of how GERD was being sed to determine if fective. on 1/15/15 at 10:05 a.m. N)-A stated, nursing did not essment for GERD and		<ol> <li>Date of completion February 24 2015</li> <li>Reoccurrence will be prevented A. Continue d service by consultar pharmacist on a monthly basis</li> <li>Continue review by Medical direct every 60 days.</li> <li>Will review recommendations a quarterly Q/A meeting.</li> <li>Correction will be monitored by: A. DON or designee</li> <li>Q/A committee will review the a results on a quarterly basis and pro- further direction as needed.</li> </ol>	d by: nt ector at : audit	
	RN-A continued to s	say any information regarding prazole probably would be				

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DEPAR	FORM	APPROVED					
CENTE		0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245369	B. WING		01/	15/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LUTHERAN HOME	E		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	2N	(X5)	
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	OULD BE COMPLETION		

Facility ID: 00394

If continuation sheet Page 16 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES		F	131,9023	FORM	: 02/10/2015 APPROVED . 0938-0391
			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245369	B. WING		-	01	/15/2015
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	KS LUTHERAN HOME				400 - 15TH AVENUE SOUTHWEST		
					AUSTIN, MN 55912		010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT ( CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio St. Mark's Lutheran substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, a Home was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	R THE FIRE SAFETY spections Division Suite 145			EPOC		
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	nically 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.

.

		AND HUMAN SERVICES			0		APPROVED 0938-0391
				CE CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
	245369					01/15/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST		
ST MAR	KS LUTHERAN HOME	:			AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	By email to: Marian Whitney@s Angela Kappenmar THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficit 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre This facility will be s buildings. St. Mark's building with a parti constructed at 4 dif building was constr determined to be of 1967, addition was that was determined construction. In 198 added to the East W be Type V(111). In to the North Wing a II (111) construction construction type a	tate.mn.us and @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency.	K	000			
	fire alarm system w	sprinklered. The facility has a rith full corridor smoke es open to the corridors that is					

Facility ID: 00394

If continuation sheet Page 2 of 9

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245369	B. WING _		01/	15/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
, К 000	monitored for autor notification. The fac and had a census of The requirement at	natic fire department cility has a capacity of 61 beds of 54 at the time of the survey. : 42 CFR, Subpart 483.70(a) is	К 00	0			
K 011 SS=D	If the building has a nonconforming buil barrier having at lea rating constructed o addition. Commun corridors and are p	Anced by: FETY CODE STANDARD a common wall with a Iding, the common wall is a fire ast a two-hour fire resistance of materials as required for the icating openings occur only in rotected by approved ors. 19.1.1.4.1, 19.1.1.4.2	K 01	1		2/11/15	
	Based on observation facility failed to provide the provident of the provi	s not met as evidenced by: tion and staff interview, the vide 2-hour fire rated ding separation wall in 000 - NFPA 101, sections ficient practice could affect all 5.		On Wednesday 2/11/15 Johns Harware Company will be here door so it is a positive latching will be completed that day, 2/11	to redo our door. This		
	01/15/2015, observ minute fire rated do	veen 9:30 AM and 1:30 PM on vation revealed, that the 90 por from Long Term Care to does not positively latch.					
		ice was confirmed by the e Director (BR) at the time of					

If continuation sheet Page 3 of 9

Chritement of Bertoletoneo		(X2) MULTIP A. BUILDING		E SURVEY PLETED		
245369			B. WING	01/	01/15/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		_		400 - 15TH AVENUE SOUTHWEST		
ST MARI	S LUTHERAN HOME	-		AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 011	Continued From pa	ge 3	K 011			
K 050	discovery. NFPA 101 LIFE SA	FETY CODE STANDARD	K 050			1/19/15
SS=D	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are the leadership. Where drills are the 9 PM and 6 AM a coded by be used instead of audible				
	Based on docume interview, the facilit were conducted on staff under varying required by 2000 N	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 54		The 2015 Fire Drill Schedule has redone so every drill is at least 1 apart for each drill on each shift p quarter. This was completed on 7 and will be scheduled like this ye forward.	1/2 hours per I/19/2015	
	01/15/2015, the rev documentation for 2014 to December for the day shifts we sufficiently vary the	veen 9:30 AM and 1:30 PM on view of the fire drill the past 12 months (January 2014) revealed that the drills ere completed but did not times that the drills were 1000, 1230 and 0900 hours.				
	This deficient pract	ice was confirmed by the e Director (BR) at the time of				

Facility ID: 00394

If continuation sheet Page 4 of 9

		AND HUMAN SERVICES				PPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					X3) DATE	
245369			B. WING		01/1	5/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	KS LUTHERAN HOME	E		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 050 K 062	discovery.	ige 4 FETY CODE STANDARD	K 05 K 06			1/27/15
SS=D	continuously mainta condition and are in	c sprinkler systems are ained in reliable operating hspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,				
	Based on observation facility failed to main accordance with NFPA 101, Section 1999 NFPA 13 sections 1999 NFPA 14 sections 1990 NFPA	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.5 and 9.7, as well as tion 5-7.4.1.1 and 1998 NFPA This deficient practice could 42 residents.		<ol> <li>on 2/4/15 Summit Fire Protection supplied us with one type of sprinkle head we we'er missing and also an e box to keep them in.</li> <li>On 1/27/15 Summit Fire Protectio came in and moved the sprinkler hea 4 inches below the ceiling.</li> </ol>	er extra	
	Findings include:				× *	
		veen 9:30 AM and 1:30 PM on ation revealed that the d:				
	1. Oxygen storage head is located less	room - the sidewall sprinkler s than 4 inches from ceiling				
	<ol> <li>Spare sprinkler</li> <li>spare sprinkler</li> </ol>	head box - does not contain heads of each type				
	Facility Maintenance	ctices were confirmed by the e Director (BR) at the time of				
K 071	discovery. NFPA 101 LIFE SA	FETY CODE STANDARD	K 07	1	2	2/2/15
here and her						

Facility ID: 00394

If continuation sheet Page 5 of 9

ATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	SURVEY _ETED
		245369	B. WING		01/1	5/2015
				STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	AUSTIN, MN 55912 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
K 071 SS=F	Rubbish Chutes, In Chutes: (1) Any existing line pneumatic rubbish directly onto any co construction to prev with a fire door asse rating of 1 hour. Al section 9.5. (2) Any rubbish chup pneumatic rubbish with automatic extir accordance with 9.7 (3) Any trash chute collection room use protected in accord (4) Existing flue-fed resistive construction 19.5.4, 9.5, 8.4, NF This STANDARD is Based on observation chute that does not Sections 19.5.4, 9.5 This deficient practi- residents Finding include: On facility tour betw	cinerators and Laundry en and trash chute, including and linen systems, that opens rridor is sealed by fire resistive vent further use or is provided embly having a fire protection I new chutes comply with the or linen chute, including and linen systems, is provided nguishing protection in 7. discharges into a trash ed for no other purpose and ance with 8.4.	K 07	<ol> <li>A new chute door was ordered 2/2/15 from ChuteDr.com and will istalled as soon as it arrives.</li> <li>A new bottom fire rated fusible II has been ordered from ChuteDr.co 2/2/15 and will be installed as soor arrives.</li> <li>We will update completion date who is the statement of the statem</li></ol>	be ink door ວm on າ as it	5

Facility ID: 00394

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMP	PLETED
		245369	B. WING	X	01/1	5/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	S LUTHERAN HOME	:		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIO DATE
K 071	Continued From pa	ge 6	K 07′	1		
	and the room the c hour fire rate room	bading door has been removed hute is located in is not a 1 om chute door is not a 1 hour				
		does not have a fusible link on				
K 076	Facility Maintenance discovery.	ctices were confirmed by the e Director (BR) at the time of FETY CODE STANDARD	K 076	5		1/20/15
SS=F	Medical gas storag protected in accord for Health Care Fac	e and administration areas are ance with NFPA 99, Standards cilities.				
		locations of greater than closed by a one-hour				
	(b) Locations for su 3,000 cu.ft. are ver 4.3.1.1.2, 19.3.2.4	pply systems of greater than ted to the outside. NFPA 99				
	Based on observa facility has oxygen compliance with the	s not met as evidenced by: tions and staff interview, the cylinders not properly stored in e requirements of 1999 NFPA 1.2. This deficient practice but of 54 residents.		1. This was checked and verified lead Maintenance man Gary Hasti yes, teh room is vented directly to outside and is now labeled as such was done on 1/19/2015	ngs that the	

Event ID: WMOJ21

Facility ID: 00394

If continuation sheet Page 7 of 9

		AND HUMAN SERVICES		ОМІ	ORM APPROVE 3 NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X IG 01 - MAIN BUILDING 01	3) DATE SURVEY COMPLETED	
		245369	B. WING		01/15/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETIC TE DATE	
K 076	01/15/2015, observ oxygen store room Golden Oak wing, f 1. unknown if room outside 2. one "E" cylinder 3. combustible em 4. light switch is loo floor These deficient pra	age 7 ween 9:30 AM and 1:30 PM on vation revealed that in the over 3000 cubic feet in the the following was found: In is vented directly to the that is not properly secured pty boxes and trash in room cated less than 5 feet off of actices were confirmed by the se Director (BR) at the time of	K 07	<ul> <li>Services brought us more holders for E Cylinders. Staff was also informed always put Cylinders int eh holders. A there is an ALL STAFF Mandatory pla Corrections meeting on 2/12/2015 ar again all staff will be educated on this This will be monitored by both the Enviromental Services Director and Maintenance personal.</li> <li>3. All Empty boxes and trash was removed from this area on 1/16/2015 staff was instructed not to leave any for boxes in this area. This will be monitored by Enviromental Services Director and Maintenance personal.</li> </ul>	to Also an of nd 3. 5 and trash staff II staff	
K 144 SS=F	Generators are ins under load for 30 m accordance with NI		K 14	4. On 1/20/2015 Fox Electric moved light switch up to 5 feet of the floor.	ten 1/31/15	
	Based on docume	s not met as evidenced by: ntation review and staff y failed to test the emergency		The thermostat on this generator wa changed out by Fox Electric on 1/31/		

PRINTED: 02/10/2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245369	B. WING		01	15/2015	
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
	S LUTHERAN HOMI			400 - 15TH AVENUE SOUTHWEST			
	S LUTHERAN HOM	-		AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
K 144	Continued From pa	age 8	K 14	4			
9 0 6 p	generators in accord of 2000 NFPA 101	rdance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. This deficient		and now meets the manufractor specifications.	ures		
	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:						
	not less than 30 per rating; (b) Loading that ma	g temperature conditions or at ercent of the EPS nameplate aintains the minimum exhaust as recommended by the					
	This deficient pract Facility Maintenand discovery.	tice was confirmed by the ce Director (BR) at the time of					
	*TEAM COMPOSI Gary Schroeder, Li	TION* ife Safety Code Spc.					

Event ID: WMOJ21

Facility ID: 00394

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PRINTED: 02/10/2015

		AND HUMAN SERVICES		ł	-5369022	FORM	02/10/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - 20013 ADDITION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING			01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME	E			00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
K 000	INITIAL COMMEN	rs	кo	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT ( CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio St. Mark's Lutherar found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					8
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St.,	R THE FIRE SAFETY spections Division			EDOC		
			IATUOE		TITLE		(X6) DATE
	Y DIRECTOR'S OR PROVID hically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE				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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/10/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - 20013 ADDITION		E SURVEY PLETED
		245369	B. WING			01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOME				00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa St Paul, MN 55101-	-	КC	000			
	By email to: Marian.Whitney@s Angela.Kappenmar						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	buildings. St. Mark's addition is a 1-story	surveyed as two separate s Lutheran Home - 2013 v building with no basement. was determined to be of Type n.					
	fire alarm system w detection and space	sprinklered. The facility has a vith full corridor smoke es open to the corridors that is natic fire department					
	The facility has a ca census of 54 at the	apacity of 61 beds and had a time of the survey.					
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by:					

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Facility ID: 00394

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		(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO.	SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		02 - 20013 ADDITION		PLETED
		245369	B, WING		01/	5/2015
AME OF F	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
	S LUTHERAN HOME	1		400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 050 SS=D	NFPA 101 LIFE SA	FETY CODE STANDARD	K 050			1/19/15
	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is ompetent persons who are e leadership. Where drills are of 9 PM and 6 AM a coded y be used instead of audible				
	Based on docume interview, the facilit were conducted on staff under varying required by 2000 N	s not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as IFPA 101, Section 18.7.1.2. ice could affect all 54		The 2015 Fire Drill Schedule has redone so every drill is at least 1 apart for each drill on each shift p quarter. This was completed on 1 and will be scheduled like this yes forward.	1/2 hours er /19/2015	
	01/15/2015, the rev documentation for 2014 to December for the day shifts w sufficiently vary the	veen 9:30 AM and 1:30 PM on view of the fire drill the past 12 months (January 2014) revealed that the drills ere completed but did not times that the drills were 1000, 1230 and 0900 hours.				
	This deficient pract Facility Maintenand discovery. NFPA 101 LIFE SA	tice was confirmed by the ce Director (BR) at the time of	K 144			1/31/15

Facility ID: 00394

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3 6 02 - 20013 ADDITION	(X3) DATE SURVEY COMPLETED	
		245369	B. WING		01/15/2015	
	PROVIDER OR SUPPLIER	E	STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION COMPLETION DATE	
K 144	Generators are ins	pected weekly and exercised ninutes per month in	K 144			
	Based on docume interview, the facilit generators in accord of 2000 NFPA 101	s not met as evidenced by: ntation review and staff y failed to test the emergency rdance with the requirements - 9.1.3 and 1999 NFPA 110		The thermostat on this generator was changed out by Fox Electric on 1/31/2 and now meets the manufractures specifications.		
	Findings include: On facility tour betw 01/15/2015, docum emergency genera to December 2014	veen 9:30 AM and 1:30 PM on nentation review of the monthly tor testing logs (January 2014 ), indicated that the facility did ural gas emergency generator				
	<ul> <li>(a) Under operating not less than 30 per rating;</li> <li>(b) Loading that mag gas temperatures a manufacturer</li> <li>This deficient pract</li> </ul>	g temperature conditions or at ercent of the EPS nameplate aintains the minimum exhaust as recommended by the tice was confirmed by the ce Director (BR) at the time of				

Facility ID: 00394

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PRINTED: 02/10/2015

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 02/10/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 02 - 20013 ADDITION	(X3) DATE SURVEY COMPLETED
		245369	B, WING _		01/15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST	
ST MAR	KS LUTHERAN HOME			AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
K 144	Continued From pa	ge 4	K 14	14	
	*TEAM COMPOSI Gary Schroeder, Li	FION* fe Safety Code Spc.			
			e.		
					investion about Page 5 of 5

Facility ID: 00394

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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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

St Marks Lutheran Home January 29, 2015 Page 2

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,

Kumalu Fiske Downing

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

Minnesc	ta Department of He	alth			-	_
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00394	B. WING		01/1	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LUTHERAN HOME	-	HAVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 02/06/15

STATE FORM

If continuation sheet 1 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00394	B. WING		01/	15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
ST MARKS LUTHERAN HOME 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Department's s and the following c Please indicate in y correction that you and identify the dat Minnesota Department's s and the following c Please indicate in y correction that you and identify the dat Minnesota Department the State Licensing federal software. To assigned to Minnes Nursing Homes. The assigned tag r column entitled "II statute/rule out of c "Summary Statement and replaces the "T correction order. The findings which are after the statement	Although no plan of correction Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the					
	Time period for Co PLEASE DISREGA FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		e survey IPleted
		00394	B. WING	01/	01/15/2015	
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		10/2010
		400 - 15T	H AVENUE SC			
	KS LUTHERAN HOME	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 540	MN Rule 4658.040 Resident Assessme	0 Subp. 1 & 2 Comprehensive ent	2 540			2/24/15
	conduct a compreh resident's needs, w capability to perform significant impairment nursing assessmen Minnesota Statutes 15, may be used as resident assessme comprehensive res used to develop, re comprehensive pla 4658.0405. Subp. 2. Informa comprehensive res include at least the A. medically de medical history; B. medical stat C. physical and D. sensory and E. nutritional st F. special treat	ion; ential; n potential; itus; r; and				

STATEMEN		alth	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/	1 5 /001 5
		00394	D. 11110		01/	15/2015
NAME OF	PROVIDER OR SUPPLIER					
ST MAR	KS LUTHERAN HOME		H AVENUE S MN 55912	SOUTHWEST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLET DATE
2 540	Continued From pa	ge 3	2 540			
	by: Based on observati review the facility fa assess the need fo services and need	ent is not met as evidenced on, interview, and document illed to comprehensively r ongoing nursing home for mental health services for 2) with identified mental health		Completion Date: February 2	4th, 2015.	
	health diagnosis an time of the admissic comprehensive ass R82's admission M 3/28/14 included dia psychotic disorder, drug abuse, and his (TBI)) and indicated with a Brief Intervie (BIMS) of 5. Also w another nursing fac Admission MDS da MDS dated 5/18/14 of mental health iss 6/24/14, and the qu R82 had a serious a disability that had b Preadmission Scree (PASRR) dated 2/2 for need of ongoing for specialized serv make a referral to t The PASRR dated 2/2 documented mental	inimum Data Set (MDS) dated agnoses of anxiety disorder, neurotic disorders, history of story of traumatic brain injury d severe cognitive impairment w for Mental Status Score as admitted on 3/21/14 from ility. ted 4/2/14 and the sixty day did not include identification sues. The quarterly MDS dated arterly MDS dated 9/24/14 mental illness or intellectual een identified on the ening and Resident Review 0/14 and failed to assess R82 nursing home care and need ices. The facility also failed to he local contact agency. 2/20/14 indicated R82 had a I illness; psychotic disorder equired short term nursing				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		00394	B. WING		01/15/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	
ST MARI	KS LUTHERAN HOM		H AVENUE S MN 55912	OUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 540	Continued From pa	age 4	2 540		
	following inpatient less than 30 days s authorization., and approved: follow up needed beyond the During an interview licensed social wor	oved: convalescent care care for the same condition, stay and includes MD written admission has been o will be required if extension is e specified time limit." v on 1/15/15, at 9:18 a.m. cker (LSW)-A verified d not address a mental illness	3		
	The director of nur staff related to com monitor for complia		)		
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		2/24/15
		omprehensive plan of care Il personnel involved in the t.			
	by: Based on observat review, the facility plan was followed concerns, related t bruises for 1 of 3 re non-pressure relate the facility failed fo	tion, interview and document failed to ensure the written care for monitoring of skin o identifying and reporting esidents (R61) reviewed for ed skin conditions, in addition llow the written care plan to or 1 of 3 resident (R15)	•	Completion date: February 24th, 201	5

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00394	B. WING		01/	01/15/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
ST MARI	KS LUTHERAN HOM		TH AVENUE SC MN 55912	DUTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 565	Continued From pa	age 5	2 565				
	reviewed for activit	ies of daily living.					
	Findings Include:						
		for bruising and timely sed staff for resident with blood :	Ŀ				
	have a bruise on th wrist with no docur	l on 1/13/2015 at 8:55 a.m. to ne back of his right hand by his mentation of the bruise being f was informed of the bruise by 5.					
	Set (MDS) dated 1 heart failure, post- diabetes mellitus. I impairment with a score (BIMS) of th assist from two sta	hange in status Minimum Data 1-8-14, identified diagnoses of traumatic stress disorder and R61 had severe cognitive brief interview for mental status ree and required extensive iff for activities of daily living, bility and transfers.					
	"Resident receives [anticoagulation-bl	dated 10/28/13 read, Coumadin ood thinner]." Interventions for signs and symptoms of					
	stated she monitor when she provided bruises to the nursi bath day the nursir completed skin ins noticed the bruise on 1/12/15 in the n R61's blood sugar, report the bruise o	a.m. nursing assistant (NA)-A red resident skin for bruising d daily cares and reported any e. NA-A stated on a resident's ng assistant and the nurse spections. NA-A stated she on the back of R23's right hand norning when she checked . NA-A stated she did not n his hand to the nurse and staff was already aware of the	1				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/	15/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		10/2010
ST MARI	KS LUTHERAN HOM		HAVENUE SO MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	bruise.					
	RN-A dated 1/14/1 bruise to resident's a bruise (dark purp hand between thur nurse aware. Bruis	e progress note completed by 5 read, "This nurse notified of RT [right] hand. Resident has ble) to RT [right] hand on top of nb and first finger. Charge e is irregular is irregular shape 4 cm [centimeters]"				
	(DON) stated she e resident skin during skin issues to the o the nurse should th the bruise, interview bruise and comple- verified the facility	a.m. the director of nursing expected staff to check g cares daily and report any charge nurse. The DON stated nen measure and note color of w the resident regarding the te an incident report. The DON did not follow R61's care plan esidents skin for bleeding.				
	to meet activities o R15 was observed sitting in her room. brown/black debris both hands. R15 was observed in her room. R15's debris underneath Again on 1/15/15, a	or resident dependent on staff f daily living skills (ADLs): on 01/13/15, at 8:52 a.m. R15's fingernails had underneath fingernails on on 1/14/15, at 2:30 p.m. sitting fingernails had brown/black fingernails on both hands. at 8:28 a.m. sitting at the dining ble. R15's fingernails had				
nnoosta D	brown/black debris both hands. R15's quarterly Mir 12/17/14, identified disease and diabet cognitive impairme mental status score	inderneath fingernails on nimum Data Set (MDS) dated diagnoses of Parkinson's tes. R15 had moderate nt with a brief interview for e of 11 and required extensive tiff for activities of daily living,				

STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/15/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
ST MARI	KS LUTHERAN HOM		H AVENUE SC MN 55912	DUTHWEST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	had a self-care def required extensive grooming. The care diagnosis of diabet nursing to provide During an interview licensed practical r was provided on sh R15's shower day in During an interview nursing assistant (I usually done after sh NA-C explained if p foot doctor cuts the them. NA-C stated care caught up. NA been cooperative w During an interview RN-B verified resid extensive assist wi Facility policy Nurs date of 5/11 read, " be clean and trimm The facility provide procedure (last rew Fingernails/Toenail procedure provided should be recorded date and time that title of individual wh and The condition bed" SUGGESTED MET The administrator of	v on 1/15/15, at 7:26 a.m. hurse (LPN)-D stated nail care hower days and as needed. is scheduled for Tuesdays. v on 1/15/15, at 7:28 a.m. NA)-C stated nail care was showers or after breakfast. beople are diabetic then the e nails but the aides clean she was trying to get the nail A-C stated R15 had always with nail care. v on 1/15/15, at 8:35 a.m. lents that are care planned th hygiene included needing th nail care. ing Care Standards last review 'Fingernails and toenails shall				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		00394	B. WING		01/15/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
	KS LUTHERAN HOMI			SOUTHWEST		
(X4) ID	SUMMARY ST	AUSTIN,	MN 55912	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET	
2 565	Continued From pa	age 8	2 565			
	system to ensure s directed by the writ	taff are providing care as ten plan of care.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		2/24/15	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to identify bruises for 1 of eviewed for non-pressure ons.		Completion Date: February 24th, 20	15	
	Findings Include:					
	have a bruise on th wrist with no docun	on 1/13/2015 at 8:55 a.m. to le back of his right hand by his mentation of the bruise being was informed of the bruise by 5.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
T MARI	KS LUTHERAN HOM		H AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	R61's significant cl Set (MDS) dated 1 heart failure, post-t diabetes mellitus. F impairment with a l score (BIMS) of the assist from two sta which included mo R61's plan of care Resident receives included: "Monitor bleeding." R61's January 201 skin audits were re documentation in r back his right hance On 12/17/14 at 2:5 (NA)-D stated she bruising when prov any bruises to the re On 1/15/15 at 7:25 stated she monitor when she provided	hange in status Minimum Data 1-8-14, identified diagnoses of traumatic stress disorder and R61 had severe cognitive brief interview for mental status ree and required extensive (ff for activities of daily living, bility and transfers. dated 10/28/13 read, " Coumadin." Interventions r for signs and symptoms of 5 progress notes and weekly eviewed and there was no egards to the bruise on the d. 5 p.m. nursing assistant monitored resident skin for <i>r</i> iding cares daily and reported				
	bath day the nursin completed skin ins noticed the bruise hand on 1/12/15 in checked R61 's blue did not report the b	ng assistant and the nurse pections. NA-A stated she on the back of R23 ' s right the morning when she ood sugar. NA-A stated she oruise on his hand to the nurse ught staff was already aware or				
	verified there was i	p.m. registered nurse (RN)-A no documentation completed ir for the bruise on the back of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00394	B. WING		01/	15/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	(S LUTHERAN HOM		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	R61 ' s right hand a had not been comp	and verified an incident report bleted.				
	RN-A dated 1/14/12 bruise to resident ' has a bruise (dark top of hand betwee Charge nurse away	e progress note completed by 5 read, " This nurse notified of s RT [right] hand. Resident purple) to RT [right] hand on en thumb and first finger. re. Bruise is irregular is d measures 5 x 4 cm				
	(DON) stated she e resident skin during skin issues to the o the nurse should th the bruise, interview bruise and complet verified the facility for monitoring of re policy for monitoring	a.m. the director of nursing expected staff to check g cares daily and report any charge nurse. The DON stated hen measure and note color of w the resident regarding the te an incident report. The DON did not follow R61 's care plan esidents skin for bleeding. A g of non-pressure related skin uested and not provided.				
	The Director of Nu develop polices an assessing and mor skin conditions. Th designee could edu procedures. The E designee could dev	THOD OF CORRECTION: rsing or her designee could d procedures regarding nitoring non-pressure related ne Director of Nursing or her ucate staff on the policies and Director of Nursing or her velop a monitoring system to ceive the appropriate care.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			2/24/15

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ST MARI	KS LUTHERAN HOM		HAVENUE S MN 55912	SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 920	comprehensive reshome must ensure B. a resident who activities of daily liv services to maintai and personal and c This MN Requirem by: Based on observat review, the facility f of 1 resident (R15) assistance to main needs. Findings included: R15 was observed sitting in her room. brown/black debris both hands. Again in her room R15 's debris underneath though R15 had as 1/15/15, at 8:28 a.r breakfast table R15 debris underneath R15's quarterly Min 12/17/14, identified disease and diabet cognitive impairme mental status score assist from one sta which included dres needs. R15's current copy had a self-care def required extensive	of daily living. Based on the sident assessment, a nursing that: b is unable to carry out ring receives the necessary n good nutrition, grooming,		Completion Date: February	24th , 2015	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/15/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2010
ST MAR	KS LUTHERAN HOM	-	TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	nursing to provide n During an interview licensed practical m was provided on sh R15's shower day i (done 1/13/2015). During an interview nursing assistant (fu usually done after show NA-C explained if p foot doctor cuts the them. NA-C stated care caught up. NA been cooperative w During an interview RN-B verified R15 care. Facility policy Nursi date of 5/11 read, " be clean and trimm The facility provide procedure (last rev Fingernails/Toenail purpose of this pro- bed, to keep nails t infections., and Nai and regular trimmin SUGGESTED MET The director of nursi ensure that resider activities of daily liv services to maintai and personal and c	hail care. on 1/15/15, at 7:26 a.m. ourse (LPN)-D stated nail care hower days and as needed. s scheduled for Tuesdays on 1/15/15, at 7:28 a.m. NA)-C stated nail care was showers or after breakfast. beople are diabetic then the e nails but the aides clean she was trying to get the nail A-C stated R15 had always with nail care. on 1/15/15, at 8:35 a.m. needed assistance with nail ing Care Standards last review Fingernails and toenails shall red." d a copy of a MED-PASS, Inc. ised October 2010) Care of s. The procedure read, "The cedure are to clean the nail rimmed, and to prevent I care includes daily cleaning ng." THOD OF CORRECTION: sing and or designee could the who are unable to carry out ing receive the necessary n good nutrition, grooming,				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST MARK	S LUTHERAN HOM		H AVENUE S MN 55912	OUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
21426	Continued From pa	age 13	21426		
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426		2/24/15
	infection control pro- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provid regarding impleme	hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.			
	by: Based on interview facility failed to ens symptoms and test admission for 4 of R13) and for 4 of 5	ent is not met as evidenced y and document review, the sure screening of active TB ting was completed upon 6 residents (R123, R85, R87, 5 newly hired employees (E1, uired for tuberculosis		completion date: February 24th, 20	015
	Findings include: Lack of newly adm	itted residents TB status:			
1	R123 was admitted				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00394	B. WING		01/	01/15/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
	(S LUTHERAN HOM		H AVENUE SC	UTHWEST			
		AUSTIN,	MN 55912			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21426	Continued From pa	age 14	21426				
	undated. Further on 12/14/14 with n	n screen completed but R123 had a documented TST egative results and no s identified for the second TST					
	the symptom scree	to the facility on 3/26/2014 and on was not completed. In yed a 2 step TST but the e not documented.					
	The vaccination his	to the facility on on 5/30/2014. story for R87 lacked the the symptom screen and					
	the vaccination his	to the facility on 10/24/14 and tory lacked evidence of nd second-step TST.					
	Lack of following T Care Workers:	uberculosis Program for Health					
		documented as 12/30/2014. If the first TST and no vas given.					
		a documented as 12/11/2014. ad documented results.					
	Also noted was tha filled out on 1/7/20 TST on 11/12/14 a The symptom scree the time of hire. The	a documented as 11/12/2014. It the symptom screen was 15. E5 received the first-step nd the second-step on 1/7/15. en for E5 was not completed at ne first and second TST's were and neither TST results were					
	E6's start date was	documented as 1/14/2015.					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00394	 B. WING		01/	15/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2010
	KS LUTHERAN HOME	400 - 151	H AVENUE SC			
		AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pa	ige 15	21426			
	TST on 1/14/15. T	nptom screen and first-step here was no second step TST ne first-step TST lacked s.				
	11:08 a.m. verified find any evidence of for all current employ this recently came	lirector of nursing on 1/15/15 at that the facility was not able to of TB screening or 2 step TSTs oyees. She further added that to her attention and the facility TST's on all employees, so the k into compliance.				
	The director of nurs review/revise polici	THOD OF CORRECTION: sing or designee, could es on resident and employee ning and perform audits to ras being followed.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	21535			2/24/15
	must be free from unnecessary drug i	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration:				
	C. without ade D. in the prese which indicate the o discontinued.	quate indications for its use; or nce of adverse consequences dose should be reduced or				
	part 4658.1310, th with provisions in th	rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section				

Minnesota Department of Health STATE FORM

6899

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		:	(X3) DATE SURVEY COMPLETED 01/15/2015	
00394	B. WING			
ER STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ME		SOUTHWEST		
AUSTIN,	MN 55912	I		
STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
page 16	21535			
in Appendix P of the State ual, Guidance to Surveyors for Facilities, published by the ealth and Human Services, ancing Administration, April 1992. incorporated by reference. It is the Minitex interlibrary loan State Law Library. It is not nt change.				
ement is not met as evidenced ew and document review, the ssess the effectiveness of ontrol gastrointestinal reflux 5 residents (R82) reviewed for dications.		Completion date: February 24th, 201	5	
Findings included:				
Minimum Data Set (MDS) dated ded a diagnosis of eal reflex disease (GERD) and cognitive impairment with a Brief ntal Status Score (BIMS) of 2. physician orders dated 3/21/14 razole [belongs to group of drugs mp inhibitors. It decreases the roduced in the stomach] 20 by mouth one tab two times a day fore meals for esophageal				
ysician orders provided by the 5 included Omeprazole 20 mg by vo times a day and has received is months. dated 4/14/14 indicated resident				
ys 5 i vo Is da	ician orders provided by the ncluded Omeprazole 20 mg by times a day and has received months.	ician orders provided by the ncluded Omeprazole 20 mg by times a day and has received months. ted 4/14/14 indicated resident ration in nutritional status	ician orders provided by the ncluded Omeprazole 20 mg by times a day and has received months. ted 4/14/14 indicated resident ration in nutritional status	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		E SURVEY PLETED	
		00394	B. WING		01/	15/2015	
AME OF F	ME OF PROVIDER OR SUPPLIER STREET			ADDRESS, CITY, STATE, ZIP CODE			
T MARK	S LUTHERAN HOM	-	H AVENUE SC MN 55912	DUTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE <sup>-</sup> DATE	
21535	Continued From pa	age 17	21535				
	10/23/14 and 12/11 Reflux. Continue C During an interview licensed practical r not complained of LPN-D was not aw monitored or asses Omeprazole was a During an interview registered nurse (F have a specific ass nursing did not ass Omeprazole was a RN-A continued to	y on 1/15/15, at 10:03 a.m. hurse (LPN)-D stated R82 had gastrointestinal upset and are of how GERD was being ssed to determine if ffective. y on 1/15/15 at 10:05 a.m. RN)-A stated, nursing did not sessment for GERD and sess or monitor if the ffective for treating GERD. say any information regarding prazole probably would be					
	The Director of Nu develop policies ar residents drug regi drugs and monitori the medications. T designee could ed Director of Nursing	THOD OF CORRECTION: rsing or her designee could ad procedures to ensure men is free of unnecessary ng for effectiveness for use of he Director of Nursing or her lucate all appropriate staff. The or her designee could develop m to ensure ongoing					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21880	MN St. Statute 144 Residents of HC F	.651 Subd. 20 Patients & ac.Bill of Rights	21880			2/24/15	
	shall be encourage their stay in a facili	nces. Patients and residents ed and assisted, throughout ty or their course of treatment, exercise their rights as					

STATEMEN	ta Department of Here T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/15/2015	
	ROVIDER OR SUPPLIER		DRESS, CITY, S			15/2015
	S LUTHERAN HOM	400 - 15T	H AVENUE SC			
	S LUTHERAN HOM	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
21880	Continued From pa	age 18	21880			
	residents may void changes in policies and others of their interference, coerc including threat of grievance procedu well as addresses Office of Health Fanursing home omb Americans Act, see posted in a conspire Every acute card residential program 253C.01, every no facility employing r provides outpatien have a written inte at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pr an impartial decisid otherwise resolved residential program 253C.01 which are treatment program centers with sectio health maintenanc 62D.11 is deemed	, and citizens. Patients and e grievances and recommend s and services to facility staff choice, free from restraint, cion, discrimination, or reprisal, discharge. Notice of the ire of the facility or program, as and telephone numbers for the acility Complaints and the area budsman pursuant to the Older ction 307(a)(12) shall be cuous place. e inpatient facility, every m as defined in section nacute care facility, and every nore than two people that t mental health services shall ernal grievance procedure that, s forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written rovides for a timely decision by on maker if the grievance is not d. Compliance by hospitals, ms as defined in section e hospital-based primary us, and outpatient surgery on 144.691 and compliance by e organizations with section to be compliance with the written internal grievance				
nesota De ATE FORM	epartment of Health		6899	MOJ11	16 11 11	on sheet 19 o

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00394	B. WING		01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	•	
ST MARI	KS LUTHERAN HOME			SOUTHWEST		
(X4) ID	SUMMARY STA	AUSTIN,	MN 55912	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
21880	Continued From pa	age 19	21880			
	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:			Completion Date: Februa	ary 24th, 2015	
	identified she was of interview for menta R23's diagnosis inc dementia, anxiety a					
		ted 12/7/2006; indicated R23 tion related to short term istory of confusion.				
	missing pearl neck R23 reported she ir was missing, stated	p.m. R23 reported she had a lace this past summer. nformed staff her necklace d it didn't seem to matter to was missing as nothing was necklace.				
	pearl necklace was reported the neckla form was incomple	en/Items Tracking form for the reviewed and revealed R23 ace missing on 1/29/14, the te and an investigation had not r the missing necklace.				
	worker (LSW)-A sta missing frequently find the missing iter not an item R23 ha the missing item tra	0 a.m. the licensed social ated R23 reported things and staff were usually able to ms or family would state it was d at the facility. LSW-A verified acking form for the missing incomplete and an				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
00394		00394	B. WING		01/15/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						10/2010
ST MARI	KS LUTHERAN HOM	-	H AVENUE SO MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	investigation was n the facility did not f and procedure whe necklace missing. On 1/15/15 at 10:2 stated her expecta follow the policy an when a resident re On 1/15/15 at 10:4 verified the facility procedure for R23' stated an investiga completed. R15's quarterly Mir identified she was impaired with a brid (BIMS) score of 11 but was not limited diabetes. R15's care plan da had impaired cogn changes to BIMS s times requiring ver	not completed. LSW-A verified ollow the missing item policy en R23 reported her pearl 9 a.m. the director of nurses tion was the facility would nd procedure for missing items ported a missing item. 4 a.m. the executive director did not follow the policy and 's missing pearl necklace and tion should have been himum Data Set dated 1/3/15, moderately cognitively ef interview for mental status also R15's diagnosis included to Parkinson's disease and tted 8/10/2013; indicated R15 ition due to intermittent scores, intermittent confusion at bal cues and times.	21880			
	been missing \$33.0 time ago. R15 reported she h missing money after stated they never g didn't get the mone	5 a.m. R15 reported she had 00 out of her dresser some nad informed staff of her er she had noticed it missing, got back to me about it and ey back. ken/Items Tracking form for the				
	\$33.00 was review the money missing incomplete and an completed for miss On 01/14/15 at 8:4	ed and revealed R15 reported on 12/4/13, the form was investigation had not been				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00394	B. WING	B. WING		15/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T MARI	KS LUTHERAN HOM		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
21880	Continued From pa	age 21	21880			
	reported missing an determined that no place because of th LSW-A verified a fu completed for that The Missing Item F "Procedure: 1. At th missing a search w was told of the miss item report sheet th station and give mi services. 2. Reside missing item sheet Service Director wi family of missing ite search is being cor	Policy dated 6/4/13 read, the time any item is reported vill be done. The person that sing item will fill out a missing that is located at each nurses ssing item form to Social ent Service Director will review and investigate. 3. Resident Il contact the resident and their em and reassure them that a inducted. 4. Resident Service pontact resident and family of	r			
	The director of soc could educate all a the process of repo The director of soc could develop mon ongoing complianc items is being done	THOD OF CORRECTION: ial services or administrator ppropriate staff members on orting missing personal items. ial services or administrator itoring systems to ensure e and follow up ion missing e. R CORRECTION: Twenty-one				
	(21) days.					
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Establish Iy Councils	21942			2/24/15
	boarding care hom advisory council an	council. Each nursing home or e shall establish a resident Id a family council, unless ersons express an interest in				

00394		B. WING		01/	15/2015
PROVIDER OR SUPPLIER					
KS LUTHERAN HOME	-		SOUTHWEST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 22	21942			
function, the nursin home shall docume council or councils year. This subdivisi residents and famil	g home or boarding care ent its attempts to establish the at least once each calendar ion does not alter the rights of ies provided by section	2			
by: Based on interview	, the facility failed to attempt to		Completion Date; Februa	ry 24th, 2015	
Findings include:					
(LSW)-A on 1/3/15, had been no active and verified that the	, at 12:55 p.m. indicated there family council in the past year ere had been no attempts by				
The individual resp to establish a family document it's effort	onsible for the annual attempt y council/group would need to is at forming a council, and				
TIME PERIOD OF (21) days.	CORRECTION: Twenty-one				
	OF CORRECTION PROVIDER OR SUPPLIER (S LUTHERAN HOMI SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa participating. If one function, the nursin home shall docume council or councils year. This subdivisi residents and famil 144.651, subdivisio This MN Requirem by: Based on interview establish a family of year. Findings include: During interview wi (LSW)-A on 1/3/15, had been no active and verified that the the facility to establ past year. SUGGESTED MET The individual resp to establish a family document it's effort identify when the ai calendar year. TIME PERIOD OF	OF CORRECTION       IDENTIFICATION NUMBER:         00394       00394         PROVIDER OR SUPPLIER       STREET AI         CS LUTHERAN HOME       400 - 151         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       SUMMARY STATEMENT OF DEFICIENCIES         CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         00394       B. WING	OF CORRECTION     IDENTIFICATION NUMBER: 00394     A. BUILDING:       *ROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       (S LUTHERAN HOME     400 - 1STH AVENUE SOUTHWEST AUSTIN, MN 55912       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY       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.     Completion Date; Februa Completion Date; Februa Sased on interview, the facility failed to attempt to establish a family council during the past calendar year.     Completion Date; Februa       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 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 cocurred in the calendar year.     IDENTIFICATION: The IDENTIFY Settempt cocurred in the calendar year.	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:       COM         00394       B. WING       01//         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         Stautherson Home       400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912       PROVIDER'S PLAN OF CORRECTION (EACH OPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREENX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OPRICENCY DO THE CORRECTION (EACH OPRICENCY DO THE CORRECTION (EACH OPRICENCY)       PROVIDER'S PLAN OF CORRECTION (EACH OPRICENCY)         Continued From page 22       21942       Consistence of the control of the 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.       Completion Date; February 24th, 2015         This MN Requirement is not met as evidenced by: Baaed on interview, the facility failed to attempt to establish a family council during the past calendar year.       Completion Date; February 24th, 2015         Completion Date; Vertical at the no attempt 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 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, andi identify when the attempt occurred in the cal