



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2026

Administrator
ST MARKS LIVING
400 15TH AVENUE SOUTHWEST
AUSTIN, MN 55912

RE: CCN:245369

Cycle Start Date: June 16, 2026

Dear Administrator:

On June 16, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 16, 2026 (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).

In addition, if substantial compliance with the regulations is not verified by December 16, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

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400 15TH AVENUE SOUTHWEST
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Re: State Nursing Home Licensing Orders

Event ID: 231A8E-H1

Dear Administrator:

The above facility survey was completed on June 16, 2026 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 - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

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Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

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Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST , AUSTIN, Minnesota, 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
E0000	Initial Comments On 6/15/26-6/16/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			07/13/2026
F0000	INITIAL COMMENTS On 6/15/26-6/16/26, a standard recertification survey (S5369039) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53692881C (iQIES #3033880). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			07/13/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -			F0812			F812 Food Procurement store/prepare/serve-sanitary Corrective actions for affected residents: No residents were identified as being adversely

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization temperatures for 1 of 1 dishwashers had been appropriately monitored to prevent the risk of foodborne illness. This had the potential to effect all 30 residents residing in the facility. Findings include: During the initial kitchen tour on 6/15/26 at 10:14 a.m., dietary director (DD)-D stated the dishwasher sanitized dishes with heat. Observed a piece of paper on a clipboard in the dishwasher room titled “dishwasher” with June 2026, written on top. The form had six columns indicating “wash” and “rinse” temperatures for each meal service: 6:00 a.m., 12:30 p.m., and 5:30 p.m. All of the wash temperatures indicated 160 degrees Fahrenheit (F). All of the rinse temperatures indicated 150 – 175 degrees F. (Required temperatures for wash are 150-165 degrees F and rinse is 180 degrees F). The rinse temperature was never documented as having reached 180 degrees F. In addition, out of 43 possible entries to document temperatures three times a day, 16 spaces were blank. During an interview and observation on 6/15/26 at 12:55 p.m., observed dietary aide (DA)-A using the dishwasher to clean silverware from the noon meal. DA-A stated wash temperature should be 160 degrees F and rinse 180 degrees F. With dishwasher in operation the wash gauge only reached 132			F0812	Continued from page 1 affected by the deficient water temperature. Immediately upon deficient practice the Certified Dietary Manager was re-educated on following up with the logs to ensure that the logs were being audited. The Certified Dietary Manager implemented the use of paper products and to use the 3-compartment sink The vendor installed a chemical system 6/17/2026 to ensure that the dishes were sanitized. The certified dietary manager received verbal education from the administrator on the oversight of the temperature logs on June 16, 2026. Identification of Other Potential affected Residents All residents have the potential to be affected by the deficiency. The vendor ordered a part for the high temperature unit. Continuation of the chemical sanitation for safety of the residents remained in place until 7/20/2026, vendor installed the booster heater fuse on 7/16/2026. A monitoring log was implemented for the correct chemical for proper sanitization of dishes. Systemic Changes The certified dietary manager implemented the following changes: A monitoring log was implemented for the correct chemical for proper sanitization of dishes. Dietary staff were educated on the chemical sanitization on 6/16 and 6/17/2026.		08/13/2026

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F0812 SS = F	Continued from page 2 degrees F and rinse reached 170 degrees F. Despite DA-A having run multiple racks through the dishwasher, neither wash nor rinse temperatures had reached required temperatures. During an interview on 6/15/26 at 1:02 p.m., with DD-D reviewed the June dishwasher temperature log. DD-D acknowledged no rinse temperatures were documented as reaching 180 degrees F. DD-D admitted she didn't monitor the logs and could not say how long the required temperatures had not been reached. DD-D stated dishwasher vendor representative (VR)-E had been there on 6/8/26, and his service visit report indicated required temperatures had been reached. During document review, additional dishwasher logs for March, April and May 2026, were reviewed. Out of three months, only one time was the required rinse temperature of 180 degrees F reached. The logs did not include what the required temperature parameters were and what staff should do if not met. During record review, the vendor report titled Service Visit Report dated 6/8/26, indicated representative VR-E had checked all chemical titrations and temperatures. The report indicated the wash temperature had reached 160 degrees F and the rinse temperature had reached 180 degrees F, yet the dishwasher log for that day did not reflect rinse temperatures of 180 degrees F. During an interview on 6/15/26 at 2:46 p.m., DD-D stated her and maintenance director (MD)-A had been working with the dishwasher, and it had taken running five loads without pausing in between to get the rinse temperature up to 180 degrees F. During an interview on 6/15/26 at 4:29 p.m., DD-D stated the kitchen would switch to paper plates and bowls until the dishwasher temperatures could be corrected and use the 3-compartment sink to wash and sanitize silverware and cups. During an interview on 6/15/26 at 5:45 p.m., VR-E had arrived on-site and had looked at the dishwasher. VR-E stated the dishwasher would hit 180 degrees F, but staff would have to run five loads through to get to that temperature. VR-E stated one of the five heating elements in the booster was out and would have to order a new one which might take three weeks to get. When asked about his service visit on 6/8/26, VR-E stated he had been able to get the required temperatures by running racks through five times. DD-D had not been informed of this, nor did the written Service Visit			F0812	Continued from page 2 The vendor will be notified of any water temperature variance for prompt correction. On 7/28/2026 the dietary staff will be re-educated on the policy review and education with staff on proper dishwashing and rinse temperatures, including the process on who to notify when temperatures are not within the range. Monitoring The dietary manager /designee will review all temperatures logs for temperature compliance: 1 x/week for 4 weeks, then 1x /month for 3 months Data will be brought to the quality committee for review and recommendations. Compliance Date 8/13/2026		08/13/2026

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F0812 SS = F	Continued from page 3 Report indicate that. Further, VR-E stated he had been aware on 6/8/26, a heating element in the booster was out, but had not ordered a replacement part. During a telephone interview on 6/16/26 at 9:43 a.m., with vendor manager (VM)-F, concerns were expressed about dishwashing rinse temperature, VR-E's service visit on 6/8/26, and the lack of communication with DD-D about findings (having to run the dishwasher five times to reach a rinse temperature of 180 degrees F and being aware the booster needed a new heating element and replacement part not ordered). VM-F stated he had been informed by VR-E and a part had been ordered today. In the meantime, they would find the part within the district and get it replaced today or tomorrow (6/16/26 or 6/17/26). During an interview on 6/16/26 at 9:53 a.m., with DD-D and administrator, both acknowledged the importance of DD-D monitoring dishwasher temperatures, ensuring staff education, and providing staff with written guidance of what temperatures needed to be and what to do if not met. During an interview on 6/16/26 at 10:59 a.m., the director of nursing (DON) and interim DON stated the facility had no incidences of food borne illness. During a telephone interview on 6/16/26 at 3:43 p.m., registered dietician (RD)-G was unaware of dishwasher temperatures not meeting required temperatures. RD-G stated her contract with the facility indicated kitchen audits upon request but had not been asked to do an audit in quite a while. RD-G stated it was necessary for required temperatures to be reached in order to properly sanitize dishes to prevent health risks to residents. Facility Ware Washing policy dated March 2021, indicated all flatware, serving dishes and cookware would be cleaned, rinsed and sanitized after use. The dish machine would be checked routinely to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Run machine until proper temperatures were reached. Record temperatures. Facility Kitchen Food Safety and Sanitation Audit, undated, indicated dishwasher temperatures at 140 degrees F wash and180 degrees F rinse. (It should be noted, 140 degrees F for wash does not meet			F0812			08/13/2026

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F0812 SS = F	Continued from page 4 CMS (Centers for Medicare & Medicaid Services) requirements.			F0812			08/13/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the			F0880	Corrective Action for identified residents All residents have the potential to affected by the deficient practice. The director of nursing/designee assessed the current infection control program for surveillance of infections. An audit was conducted by the director of nursing to identify any residents that may have been impacted. Any identified concerns were corrected The infection preventionist was educated regarding infection prevention program by the nurse consultant and other resources. The infection prevention policy was reviewed and updated as needed. The infection prevention program was re-initiated after review of the current concerns. Systemic Changes The infection prevention policy was reviewed and updated. The infection preventionist was educated on 7/15/2026 by the Regional Nurse Infection Preventionist received her certificate on 6/25/2026 The infection preventionist has initiated tracking of active infections through the vendor platform. The data collection includes mapping, surveillance		08/13/2026

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F0880 SS = F	Continued from page 5 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure ongoing surveillance for infections, ongoing review of surveillance data, and documentation of follow-up activity and response. This practice had the potential to affect all 30 residents residing in the facility. In addition, based on observation and interview, the facility failed to ensure a glucometer (a small portable device used to measure the amount of glucose in a drop of blood) used on multiple residents, had been disinfected after use on 1 of 1 resident (R17), reviewed for infection control practices. Findings include: SURVEILLANCE Review of the facility infection control binder provided 6/15/26, did not include line listing, mapping, or surveillance data for tracking and monitoring infections in the facility. During interview on 6/16/26 at 3:30 p.m., registered nurse (RN)-A stated she was new, had just started yesterday, and was hired to be the infection			F0880	Continued from page 5 and line listing to identify current infections and any potential risk of infection to others. Monitoring The infection preventionist/designee will conduct audits of any residents identified as having an infection 2 x per week for 4 weeks and 1x per week for 3 months. The infection preventionist will review surveillance data 1 x per week for 4 weeks, then 1 x month x 3 months. Results will be reported to QAPI for review and recommendations. Corrective action for residents affected The glucometer identified during survey was immediately cleaned and disinfected according to facility protocol for disinfectant. All residents that use a glucometer were assessed by the Director of Nursing/designee to determine risk of infection. The director of nursing began education to licensed nurses and trained medication aides on proper disinfection protocols for glucometers. Identification of other residents at risk All residents utilizing a glucometer to monitor blood sugars have the potential to be affected. The director of nursing/infection preventionist/designee conducted an audit to identify all other residents that use a glucometer that may have been affected. Any concerns were corrected immediately		08/13/2026

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F0880 SS = F	Continued from page 6 preventionist. RN-A stated she had searched the prior infection preventionist's office and was unable to locate any infection control tracking, data, surveillance, or mapping documents. During interview on 6/16/26 at 3:32 p.m., interim director of nursing (IDON) stated the prior infection preventionist had left on short notice and they had just replaced her with RN-A. IDON stated she was unable to find any evidence of surveillance or tracking of infections and had not implemented a new method. IDON stated she knew it was a problem and planned to start the program from scratch. IDON had her infection preventionist certificate and planned to have RN-A acquire hers as well. IDON further stated the infection prevention program was not up to her standards and needed to be improved. Facility policy on infection control and prevention was requested but not received. GLUCOMETER CLEANING: R17's face sheet received on 6/17/26, included diagnosis of diabetes. R17's admission Minimum Data Set (MDS) assessment dated 5/22/26, indicated R17 had diabetes and had received insulin injections in the last 7 days or since admission. R17's physician orders dated 6/3/26, indicated to check blood glucose per device daily at random times, one time a day every 3 day(s). R17's care plan dated 6/12/26, indicated R17 was at risk due to complications of diabetes, and to perform blood sugars per glucose monitor as ordered. During an observation on 6/16/26 at 8:11 a.m., licensed practical nurse (LPN)-C entered R17's room with a small, two-sided plastic tote with handle to obtain a fingerstick glucose. LPN-C removed the glucometer from the tote, obtained the blood sugar, then put the glucometer back into the tote on top of unused needles, without disinfecting it. LPN-C set the tote at the nurses station and sat down to document in the electronic medical record. During an observation on 6/16/26 at 8:25 a.m., observed LPN-C helping pass breakfast trays, then returned to the nurses station. Glucometer not disinfected. During an interview on 6/16/26 at 10:15 a.m., LPN-D			F0880	Continued from page 6 Systemic Changes Re-education to all licensed nursing staff and trained medication aides 6/25/2026 on the facility infection prevention and control policy, the facility protocol for disinfecting glucometers. All residents will have their own glucometer. Monitoring The infection preventionist/designee will conduct glucometer cleaning audits 2 x per week x 4 weeks, then 1 x per week for 2 months. Results will be reported to QAPI for review and recommendations Completion 8/13/2026		08/13/2026

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F0880 SS = F	Continued from page 7 stated LPN-C had left at 10:00 a.m., and LPN-D had not used the glucometer since coming on duty at 10:00 a.m., nor would she need to. During a telephone interview on 6/16/26 at 10:22 a.m., LPN-C admitted she did not disinfect the glucometer after use on R17 – stated she didn't think to and knew she should have disinfected it with a disinfectant wipe to prevent transfer of germs. LPN-C stated the glucometer was used for multiple residents and she had not used it after R17, but acknowledged another nurse could have. During an interview on 6/16/26, at 10:45 a.m., the director of nursing (DON) was informed of findings. The DON expected nursing staff to disinfect glucometers after use to prevent transmission of infection, and called the transitional care unit to ask staff to disinfect the glucometer and the contents of the tote. Facility Glucometer Disinfection policy, undated, indicated the purpose was to prevent cross-contamination and the transmission of infectious diseases during blood glucose monitoring by ensuring proper disinfection. If a glucometer was shared among residents, it must be cleaned and disinfected according to manufacturer recommendations between each use. After testing, disinfect the glucometer before use on another resident using an approved disinfectant wipe. Thoroughly wet all external surfaces of the glucometer and follow the disinfectant manufacturer's required contact time (typically 1–2 minutes or as directed). Allow the glucometer to air dry completely before reuse.			F0880			08/13/2026
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review to			F0881	Corrective Action for identified residents All residents were identified to have the potential to be affected The Director of nursing designee reviewed all residents' medical records that have an antibiotic medication in use to identify a time-out initiation if necessary and provide any discrepancies were clarified with MD The director of nursing/designee conducted a review of current residents to verify indication, duration and documentation of antibiotic review.		08/13/2026

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F0881 SS = F	Continued from page 8 determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect all 30 residents residing in the facility. Findings include: Review of the facility infection control binder provided on 6/15/26, indicated no antibiotic tracking for correct indications, dosage, duration, resistance, and no 72-hour time-outs (a check that the resident is on the right antibiotic) to review cultures and verify correct antibiotics or resistance to prescribed antibiotics. During interview on 6/16/26 at 3:30 p.m, registered nurse (RN)-A stated she was new to the facility, had been hired to be the infection preventionist, and had not had time to start working on an antibiotic stewardship program. RN-A further stated she was unable to find any documents from the prior infection preventionist to show that antibiotic usage was being tracked and monitored. During interview on 6/16/26 at 3:32 p.m., interim director of nursing (DON) stated the prior employee in charge of antibiotic stewardship had left on short notice. Interim DON was unable to find any evidence of tracking of antibiotic usage for correct dosage, duration, resistance, or that 72-hour time-outs were being completed to ensure proper antibiotic use. Interim DON stated she was aware this was a problem at the facility and would need to get the program restarted. Interim DON stated this was an area that needed improvement and that antibiotic usage should be monitored to ensure residents are getting the correct treatment and prevent worsening of symptoms. Facility policy on antibiotic stewardship was requested but not received.			F0881	Continued from page 8 Systemic Changes The facility reviewed the antibiotic stewardship policy for any changes The infection preventionist was educated on antibiotic stewardship July 15, 2026. The infection preventionist/designee will implement the use of a tracking tool to within the vendor platform to assist in the identification of appropriate indications, dosage, duration, trends of antibiotic use and to monitor for resistance. DON doing education to all licensed nurses on 7/30/2026 educating on St. Marks Antibiotic stewardship program. Monitoring The infection preventionist/designee will monitor all residents that are receiving antibiotics per the antibiotic stewardship program 1 x per week x 4 weeks, then 1 x per month for 3 months. Results will be reported to QAPI for review and recommendations. Completion 8/13/2026		08/13/2026
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike			F0921	Corrective Action for identified residents The stained carpeting was immediately assessed by the environmental services director. The carpet was cleaned in wing Golden Oak which is also known as 4/5 on 6/17/2026. Identification of other residents potentially affected		08/13/2026

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F0921 SS = E	Continued from page 9 environment for residents residing in Golden Oak Hall resulting in numerous large, dark stains throughout the hallway carpeting. This had the potential to affect all 20 residents who resided on the Golden Oak Hall. In addition, the facility failed to repair gaps in an exterior service door allowing the potential for rodents to enter the building. This had the potential to affect all 30 residents who resided in the facility. Finding include: CARPETING On 6/16/26 at 4:00 p.m., observation of the Golden Oak Hall resident hallway revealed multiple dark brown to gray discolorations and stains embedded throughout the carpeted surface. Several stains measured approximately 1 to 3 feet in diameter and were irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The carpeting appeared worn and soiled, with numerous spots giving the appearance of repeated liquid spills that had penetrated the carpet. Multiple overlapping stains created a large area of visible discoloration extending across a significant portion of the walking path. On 6/16/26 at 4:08 p.m., the interim director of nursing (IDON) observed the hallway carpeting on the Golden Oak Hall and stated the carpet had been shampooed approximately two weeks earlier. The IDON confirmed the carpet was stained and stated, "It does not look good," and further stated the carpet needed to be replaced. On 6/16/26 at 4:09 p.m., nursing assistant (NA)-A, NA-B, and NA-C stated the carpet stains throughout Golden Oak Hall were an ongoing concern and not a recent occurrence. NA-A, NA-B, and NA-C stated the carpeting had been shampooed a couple of weeks earlier and confirmed numerous stains remained visible throughout the hallway. NA-A, NA-B, and NA-C stated a beverage cart routinely sits in the hallway and spills occur in the area. NA-B confirmed the condition of the carpeting observed was consistent with its typical appearance and that the staining had been present for an extended period of time.			F0921	Continued from page 9 All residents have the potential to be affected. An inspection of all other resident care areas were assessed. Any additional noted areas were cleaned System Changes A carpet cleaning policy was initiated. The environmental service director was educated on 7/15/2026. A professional carpet cleaner will service the affected area on 8/11/2026. Carpet cleaning was added to the routine maintenance list All staff were educated on 8/5/2026 on protocols to clean a spill. Monitoring An audit of the maintenance checklist will be conducted by the environmental services director/designee 1 x per week x 4 weeks, then 1 x per month x 3 months. Reports will be brought to QAPI for recommendation and review. Corrective action for residents found to be affected All resident had the potential to be affected by the deficient practice Upon identification of the deficient practice, the service entrance door was immediately inspected		08/13/2026

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F0921 SS = E	Continued from page 10 On 6/16/26 at 4:29 p.m., the maintenance director (MD)-A confirmed the carpets in the Golden Oak halls were not clean and acknowledged the appearance and condition of the carpets did not provide a homelike environment. MD-A stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 6/16/26 at 4:49 p.m., the administrator stated the carpeting in the Golden Oak Hall had not been adequately maintained and needed replacement. The administrator stated a professional carpet company evaluated the carpeting the previous fall and indicated replacement was needed. The administrator stated maintenance staff shampooed the carpet approximately three weeks earlier, but the carpeting again appeared heavily stained. The administrator further stated moisture, spills, and coffee spills were contributing factors and acknowledged spills were not always addressed immediately. The administrator stated the carpeting "does not look good or homelike," confirmed awareness of the condition, and agreed the carpeting should be replaced. Facility Quality of Life: Home Environment Policy dated 8/25, indicated: The agency/facility will ensure that each patient/resident resides in an environment that is safe, clean, comfortable, and supportive of dignity, independence, and overall quality of life. The home environment shall promote well-being and enable the individual to perform activities of daily living to the highest practicable level. Purpose: To establish guidelines for assessing, maintaining, and improving the patient/resident's home or living environment to promote safety, support independence, maintain comfort, and comply with regulatory standards. Policy Guidelines 1. Ensure environmental safety (lighting, temperature, fall prevention). 2. Maintain cleanliness and sanitation. 3. Promote a homelike atmosphere. Assessment Requirements: Environment must be assessed on admission, periodically, and with changes in condition.			F0921	Continued from page 10 The gap was repaired by the maintenance director on 6/16/2026. The maintenance director/designee completed a facility wide door inspection of all exterior doors. Any identified concerns were added to the maintenance repair log. Systemic changes The maintenance director/designee added exterior doors to the door log. Proper documentation of findings will be kept in a binder. Education was provided to staff on door gaps, when to notify maintenance on 8/5/2026 Monitoring The environmental services director/designee will audit exit doors 1 x per week x 4 weeks, then 1 x month x 3 months. Completion 8/13/2026		08/13/2026

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F0921 SS = E	Continued from page 11 Intervention and Follow-Up: Address hazards promptly, report unresolved issues, and involve appropriate resources. SERVICE DOOR During the initial kitchen tour on 6/15/26 at 10:14 a.m., with dietary director (DD)-D, observed the double service entrance door that exited the building near the kitchen to the dumpsters outside. The metal door had a gap where the two doors met and was visible by the amount of daylight coming through. DD-D stated the facility had mice in the past and had switched to a different pest control company. DD-D stated she would talk to maintenance director (MD)-A about fixing the door. Resident council meeting minutes dated 3/16/26 and 4/20/26, indicated: Rodents - Pest Control has been called. During an interview on 6/15/26 at 2:45 p.m., family member FM-A stated she had observed mice in R5's room within the last month. FM-A stated the facility had been notified and addressed the issue. During an interview and observation on 6/16/26 at 4:10 p.m., with DD-D and MD-A, observed the gap in the service door. MD-A stated he had been aware of it but didn't know how he could fix it and a new door would be expensive. During an interview on 6/16/26 at 615 p.m., the administrator had been made aware of the gap in the service entrance door and had talked to MD-A about the need to replace it. Facility policy was requested and not received.			F0921			08/13/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.			F0641	F641- Accuracy of Assessments How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident R6's quarterly MDS assessment was immediately reviewed by the MDS Coordinator and Director of Nursing. The assessment was determined to contain inaccurate coding in Section N for opioid and diuretic medications. The resident's Medication Administration Record		08/13/2026

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F0641 SS = D	Continued from page 12 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 1 of 5 residents (R6), reviewed for unnecessary medications, when the MDS did not reflect opioid (a narcotic pain medication) and diuretic (increases urine production) medications R6 had been receiving. Findings include: R6's face sheet received on 6/17/26, included diagnoses of Parkinson's disease, high blood pressure, congestive heart failure (the heart muscle is too weak to pump blood efficiently), and was receiving hospice care. R6's quarterly Minimum Data Set (MDS) assessment dated 5/28/26, indicated moderate cognitive impairment, clear speech, could understand and be understood, required substantial assistance or was dependent on staff for activities of daily living. The MDS, section N for medications, did not include the diuretic and opioid medications R6 had been receiving. The section for diuretics and opioids had been signed off as completed by the MDS nurse on 6/10/26.			F0641	Continued from page 12 (MAR) and supporting clinical documentation were reviewed to verify medications administered during the Assessment Reference Date (ARD) look-back period. A Modification Request was completed and submitted to correct the MDS assessment in accordance with the current RAI User's Manual requirements. No adverse resident outcome occurred as a result of the inaccurate MDS coding. Identification of other residents All residents have potential for MDS miscoding of Section N. An audit of all MDS assessments completed June 16, 2026 through June 30, 2026 to verify medication coding accuracy in Section N. Correct any identified inaccuracies through the MDS modification process. Systemic changes to prevent recurrence The Director of Nursing/designee performed education to the MDS Coordinator on June 22, 2026 Educate the MDS Coordinator and interdisciplinary team on RAI Manual requirements, with emphasis on Section N medication coding. A medication coding checklist will be implemented to prevent coding medication errors. Monitoring to ensure ongoing compliance The Director of Nursing/designee will conduct; Audits of Section N of the MDS for all current residents x 30 days.		08/13/2026

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F0641 SS = D	Continued from page 13 R6's orders indicated the following: --Ordered on 10/10/25, a diuretic: furosemide oral tablet, 30 mg (milligrams) by mouth two times a day for edema (swelling caused by excess fluid trapped in body tissue). --Ordered on 5/11/26, an opioid: fentanyl transdermal patch 72-hour, 12 MCG/HR (micrograms per hour), apply 1 patch transdermal one time a day every 3 days for pain. R6's MAR (medication administration record), indicated R6 received furosemide twice a day in May and June 2026, and fentanyl patch every third day since ordered in May 2026. R6's care plan dated 3/5/26, indicated congestive heart failure and to administer diuretic medication as ordered and to monitor for side effects and effectiveness every shift. Care plan with revised date of 3/2/26, indicated R6 was at the end stage of life and was utilizing hospice services and would be comfortable. During an interview on 6/16/26 at 3:53 p.m., the director of nursing reviewed R6's orders, MAR and MDS and stated diuretic and opioid medication should have been checked-marked on the MDS indicating R6 had been receiving those medications at the time of the quarterly review. The DON indicated they did not have a policy on accuracy of MDS as it was the expectation the RAI (resident assessment instrument) manual directions were followed.			F0641	Continued from page 13 Three residents' MDS, focusing on Section N, will be audited 1x/month for 3 months. Results of the audit findings will be reported to Quality Assurance and Performance Improvement (QAPI) Committee for any further review and recommendations. Compliance: 8/13/2026		08/13/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document			F0684	F684- Quality of Care- Order/Notification CORRECTIVE ACTION FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED R1's physician-ordered wound treatment was immediately reviewed with the licensed nursing staff responsible for the resident's care. The licensed nursing staff was immediately educated on following physician orders by the IDON. R1's current wound treatment orders, wound status, and skin assessment documentation were reviewed by the Director of Nursing		08/13/2026

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F0684 SS = D	Continued from page 14 review, the facility failed to follow physician orders during a dressing change and failed to assess and document the condition of finger wound during weekly skin assessments for a non-pressure skin condition for 1 of 2 residents (R1) reviewed for non-pressure skin.. In addition, based on interview and document review, the facility failed to ensure physician orders were carried out for 1 of 1 residents (R3) reviewed for unnecessary medications, when a physician was not informed of elevated blood sugar levels. Findings include: DRESSING CHANGE/ WOUND ASSESSMENT R1's significant change in status Minimum Data Set (MDS) assessment dated 5/24/26, indicated cognitively intact, setup or clean up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with dressing, personal hygiene and dependent with toileting hygiene and diagnoses included Cerebral Palsy (disease of the developing brain and nervous system that leads to abnormal muscle tone, movement and posture), and rash and other nonspecific skin eruption. R1's care plan dated 4/1/26, indicated R1 was at risk for skin infections due to frequent refusal of showers and interventions included monitor for signs and symptoms of skin infection: redness, warm to touch, drainage, or pain. R1's Wound Care provider note dated 5/19/26, indicated wound Location: right index finger: wash hands, remove old dressings, cleanse wound bases with acetic acid (must be refrigerated after opening, discard remainder after one week), paint wound base with Betadine (if wound starts to feel mushy or has drainage underneath, contact wound clinic for debridement), cover with soft dry gauze, change dressing daily R1's treatment administration record (TAR) dated 6/1/26-6/30/26, indicated: start date 3/23/26 weekly skin assessment-document under assessments every day shift every Wednesday; start date 5/19/26, right index finger: cleanse wound beds with acetic acid. Paint with betadine. (If wound starts to feel mushy or has drainage underneath,			F0684	Continued from page 14 The resident's care plan and treatment documentation were reviewed. The Director of Nursing/designee reviewed the resident's wound order and any other documentation related. Any changes were addressed. IDENTIFICATION OF OTHER RESIDENTS WHO MAY HAVE BEEN AFFECTED Any residents with wound care orders could be affected by the practice. To ensure no other residents were affected: The Director of Nursing/designee conducted a review of current residents with wound or skin treatment orders. The wound nurse reviewed resident's orders that have current skin treatments ordered and ensured all supplies and medications were available. Any discrepancies were immediately addressed. SYSTEMIC CHANGES Education was provided to all licensed nurses on 6/25/26 regarding wound care protocols. Wound policy will be added to onboarding education for licensed nurses MONITORING The Director of Nursing/ designee will conduct audits of licensed nurses performing wound or skin treatments on 3 wound treatments per week x4 weeks, then 4 wound treatments per month x3 months Audits will be reported to QAPI for review and recommendations.		08/13/2026

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F0684 SS = D	Continued from page 15 contact Wound Clinic for debridement), cover with soft dry gauze, change dressing daily, every evening shift for wound care. R1's skin assessments indicated: 5/18/26, right hand 2nd digit TX (treatment) in place, continues with wound on right hand 2nd digit. Tx orders in place. 5/20/26, continues with wound on right hand 2nd digit. Tx orders in place. 5/21/26, continues with wound on right hand 2nd digit. Tx orders in place. 5/27/26, continues with wound on right hand 2nd digit. Tx orders in place. Nail missing, finger red. 6/2/26, documentation did not include finger assessment 6/3/26, buttocks generalized, moisture associated skin damage (MASD) 6/9/26, buttocks generalized, moisture associated skin damage (MASD) On 6/15/26 at 5:16 p.m., R1 was seated in a wheelchair in the dining room and R1's right second finger was observed with a bandage covering the tip of the finger. On 6/15/26 at 5:44 p.m., licensed practical nurse (LPN)-A stated R1 had daily dressing change orders for the finger. LPN-A stated they completed earlier today (6/15/26) and included removal of the bandage and application of acetic acid. LPN-A confirmed Betadine had not been applied because they did not believe it was part of the order. LPN-A then reviewed the physician order in the electronic medical record (EMR) and acknowledged Betadine was included in the order and should have been applied during the dressing change. LPN-A stated she had only viewed part of the order and did not realize Betadine was required. LPN-A further stated			F0684	Continued from page 15 CORRECTIVE ACTION FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED R3's blood glucose monitoring orders were verified for notification parameters to the provider by the Director of Nursing 6/16/2026 R3 was assessed for any adverse effects of the delayed notification of elevated blood glucose and any changes per physician were implemented. R3's recent blood glucose results were reviewed for values meeting the provider notification parameters. The DON or designee reviewed the medical record for evidence of provider notification, follow-up assessment, and interventions. IDENTIFICATION OF OTHER RESIDENTS WHO MAY HAVE BEEN AFFECTED There is potential for residents with blood sugar parameters that could be affected. In order to ensure no other residents were affected St. Marks did: The DON or designee conducted a review of current residents with physician-ordered blood glucose monitoring parameters for physician notification. Any discrepancies identified were addressed immediately. SYSTEMIC CHANGES All licensed nursing staff were educated regarding standing orders, specific resident orders and notification to provider when results are outside of parameters July 30,2026. The facility will reinforce the use of the electronic medical record and existing notification processes to ensure that provider notification and follow-up are documented in a manner that can be readily verified.		08/13/2026

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F0684 SS = D	Continued from page 16 Betadine had not been applied during dressing changes the previous week. LPN-A stated R1's finger should have been included in weekly skin assessments and staff would be expected to document the condition of the finger during those assessments. On 6/15/26 at 5:51 p.m., LPN-A was observed to complete dressing change of R1's right index finger and found Betadine in R1's room and applied the Betadine and gauze to R1's. LPN-A stated Betadine should be applied according to the physician's order. On 6/15/26 at 6:29 p.m., interim director of nursing (IDON) and DON stated R1's weekly skin assessments were completed on 5/24/26, 5/27/26, 6/3/26, and 6/9/26. IDON confirmed not all the skin assessments included an evaluation of the R1's finger wound. IDON stated she would expect R1's finger to be assessed and documented during skin checks to determine whether the condition was improving or worsening. IDON further stated she would expect Betadine to be applied during dressing changes because it was included in the physician's order. On 6/16/26 at 3:45 p.m., LPN-B stated weekly skin assessments should include an assessment of R1's finger wound and documentation was expected describing the appearance of the finger to determine whether the condition was improving or worsening over time. Facility Skin Assessment Policy dated 1/25, indicated Policy to conduct comprehensive skin assessments for all residents to prevent, identify, and manage skin integrity issues, including pressure injuries, wounds, infections, and other dermatologic conditions. Purpose: To establish guidelines for assessing, documenting, and managing residents' skin conditions to promote skin health, prevent complications, and ensure timely interventions. Procedure: 1. Initial Skin Assessment • A comprehensive skin assessment shall be conducted upon admission by a licensed			F0684	Continued from page 16 MONITORING The DON or designee will conduct audits of blood sugar monitoring including provider notification of results not within parameters for 3 resident charts per week x4 weeks, 3 resident charts per month x3 months. Results will be reported to QAPI for review and recommendations. COMPLETION 8/13/2026		08/13/2026

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F0684 SS = D	Continued from page 17 nurse. • Assessment findings shall be documented in the resident's medical record, noting any existing wounds, pressure injuries, bruises, rashes, or other abnormalities. • If skin integrity issues are identified, appropriate interventions shall be implemented immediately, and the physician and interdisciplinary team shall be notified. 2. Routine Skin Assessments • Daily Observations: CNAs shall observe residents skin during routine care (bathing dressing, repositioning) and report concerns to the charge nurse. • Weekly Skin Checks: RNs or LPNs shall perform full-body skin assessments on high-risk residents (e.g., those with limited mobility, incontinence, or a history of pressure injuries). • Comprehensive Assessments: Skin integrity shall be reassessed at least quarterly or upon significant change in condition. 4. Wound Care Management • Any new or worsening wounds shall be assessed and documented, including size, depth, color, drainage, and signs of infection. • The wound care team or physician shall be consulted for appropriate treatment plans. • Wound care treatments shall be performed as prescribed and documented in the resident's record. 5. Documentation and Reporting • All skin assessments, findings, and interventions shall be documented in the resident's electronic health record (EHR). • Any significant skin changes shall e reported to the physician, family, and interdisciplinary team. 6. Staff Training • All nursing staff shall receive annual training on skin assessment, wound care, and pressure injury prevention. • New employees shall be oriented on this policy and proper skin assessment techniques.			F0684			08/13/2026

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F0684 SS = D	Continued from page 18 Compliance and Quality Assurance: • The facility's Quality Assurance Committee shall review skin integrity trends and outcomes to improve resident care. • Audits of skin assessments and documentation shall be conducted periodically to ensure compliance with this policy. ELEVATED BLOOD SUGAR LEVELS R3's face sheet received on 6/17/26, included diagnosis of diabetes mellitus (metabolic disease, causing high blood sugar levels). R3's quarterly Minimum Data Set (MDS) assessment dated 5/5/26, indicated intact cognition, speech clear, was understood and able to understand. R3 required substantial staff assist or was dependent on staff for activities of daily living. R3's care plan with revised date of 5/9/23, indicated R3 was at risk for complications related to diabetes mellitus; diabetes medication and/or insulin as ordered and blood sugars per glucose monitor as ordered. R3's physician orders all dated 3/5/26, indicated the following with each order including to notify the provider if blood sugar (BS) over 400 mg/dl (milligram per deciliter): --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 23 unit subcutaneously one time a day. Notify provider if BS (blood sugar) less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 25 unit subcutaneously one time a day. Notify provider if BS less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 27 unit subcutaneously one time a day. Notify provider if BS less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 179 = 0; 180 - 219 = 2 units; 220 - 259 = 4 units; 260 - 299 = 6 units; 300 - 339 = 8 units; 340 - 379 = 10 units; 380 - 399 = 12 units; 400+ = 15 units, call provider.			F0684			08/13/2026

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F0684 SS = D	Continued from page 19 During record review, R3's blood sugar readings over 400 mg/dl included: 5/25/26 at 12:52 p.m. and 12:58 p.m., 479 mg/dl 5/29/26 at 7:41 p.m., 410 mg/dl 5/30/26 at 10:54 a.m. and 11:51 a.m., 424 mg/dl 5/31/26 at 8:12 p.m., 426 mg/dl 6/1/26 at 5:17 p.m., 447 mg/dl 6/1/26 at 9:38 p.m., 427 mg/dl 6/5/26 at 8:32 p.m., 420 mg/dl 6/8/26 at 8:30 p.m., 498 mg/dl 6/10/26 at 11:34 a.m., 416 mg/dl 6/10/26 at 5:01 p.m., 402 mg/dl 6/11/26 at 3:35 p.m., 437 mg/dl 6/11/26 at 5:19 p.m., 473 mg/dl 6/11/26 at 8:00 p.m., 4:39 mg/dl 6/13/26 at 8:07 p.m., 430 mg/dl 6/16/26 at 8:21 p.m., 448 mg/dl During an interview on 6/16/26 at 8:48 a.m., license practical nurse (LPN)-C stated nurses would know when a provider wanted to be notified of a low or high blood sugar if it was included in an order. In addition, LPN-C stated a nurse could also Hoover over an electronic order in the MAR (medication administration record). LPN-C hovered over R3's insulin order in the MAR and it indicated a sliding scale, and if blood sugar was 400+, give 15 units and notify provider. LPN-C looked in progress notes and of the blood sugars greater than 400 ml/dl, a provider was notified of the BSs over 400 mg/ml on 6/1/26, and 6/11/26, but not the other 10 dates. During an interview on 6/16/26 at 3:36 p.m., with the director of nursing (DON) and interim DON (IDON), informed of findings of blood sugars over 400 mg/dl and provider not informed. IDON stated this had been a problem; they had done some nurse education in spring 2026, on notifying providers on changes in condition, and when orders indicated			F0684			08/13/2026

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F0684 SS = D	Continued from page 20 they wanted to be notified. After reviewing the electronic medication record, neither the DON nor the IDON could verify with certainty the providers were informed of the blood sugars over 400 mg/dl (other than 6/1/26 and 6/11/26). Facility Compliance with Physician orders policy dated 8/2025, indicated the purpose was to ensure all physician (or authorized provider) orders were accurately received, documented, communicated, and implemented in a timely and safe manner to promote optimal resident care and compliance with regulatory standards. All nursing staff must follow physician orders precisely as prescribed. Orders must be verified, documented, and executed promptly unless contraindicated or unclear, in which case clarification must be obtained before implementation.			F0684			08/13/2026
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			F0628			

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F0628 SS = A	Continued from page 21 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:			F0628			08/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST , AUSTIN, Minnesota, 55912			
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F0628 SS = A	Continued from page 22 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			F0628			08/13/2026

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F0628 SS = A	Continued from page 23 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).			F0628			08/13/2026

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F0628 SS = A	Continued from page 24 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the Ombudsman of discharge for 1 of 1 residents (R36) reviewed for discharge. Findings include: R36's face sheet received on 6/17/26, included diagnosis of cerebral infarction (stroke). R36's admission Minimum Data Set (MDS) assessment dated 3/18/26, indicated intact cognition, clear speech, could understand and be understood, independent or required partial assistance from staff for activities of daily living. R36's physician orders dated 3/12/26, included orders for evaluation and treatment for physical, occupational and speech therapy. R36's care plan dated 3/12/26, included functional rehabilitation and discharge planning. During record review, progress note written by social worker (SW)-A dated 3/31/26 at 8:42 a.m., indicated R36 had participated in and completed short-term rehab and was discharged home via private vehicle. During record review, a form titled Notice of Resident/Patient Transfer or Discharge completed for R36 had a section at the end indicating: Use this section to note who the notice was given to or mailed to. Have the staff member who delivered or mailed the notice sign and date it when they delivered or mailed the notice. Then there were boxes to check: 1) resident 2) representative 3) office of ombudsman 4) NA, mailed. None of the boxes were checked. The form was signed by SW-A and R36 on 3/31/26. During an interview on 6/16/26 at 3:19 p.m., SW-A verbalized the process for resident discharges, but did not inform the ombudsman of transfers or discharges as she wasn't aware she was supposed to. During an interview on 6/16/26 at 3:56 p.m., interim director of nursing (IDON) contacted the administrator via phone to ask who was responsible for notifying the ombudsman about transfers and discharges. The administrator informed IDON it was the responsibility of SW-A. In an email reply from the ombudsman dated			F0628			08/13/2026

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F0628 SS = A	Continued from page 25 6/17/26 at 8:59 a.m., the ombudsman indicated the Office of the State Long-Term Care Ombudsman had received three discharge/transfer notices in April and May 2026, from the facility, but not for R36. The ombudsman stated SW-A had reached out to her on 6/16/26, and that she sent SW-A a printable link to what information SW-A needed to send and when to send it. Facility Transfer or Discharge Notice policy with revised date of 5/2/25, indicated a copy of the notice of transfer given to the resident and/or resident representative would be sent to the Office of the State Long-Term Care Ombudsman.			F0628			08/13/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/16/2026 At the time of this survey, ST MARKS LIVING was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			07/20/2026

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 reverse for further 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.

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

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K0000 Bldg. 01	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST. MARKS LIVING is a one-story building, with a partial basement The building was constructed at (5) different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1967, an addition was constructed to the East Wing that was determined to be of Type II (111) construction. In 1981 an addition was constructed to the East Wing and was determined to be of Type V (111) construction. In 1991 an addition was constructed to the North Wing and was determined to be of Type II (111) construction. In 2003 another addition was constructed and was determined to be of Type V (111) construction. Because the original building and the (4) additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.			K0000			07/20/2026

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K0000 Bldg. 01	Continued from page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/20/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.3.2. These deficient findings could have a widespread impact on the residents within the facility.			K0353	K353 sprinkler system maintenance and testing Corrective action for deficient practice: The maintenance director/designee called the sprinkler system company for clarification of discrepancies from the documentation and the riser hangers. Sprinkler heads adjacent to the HVAC and kitchen were immediately cleaned of debris. Missing or incomplete documentation was obtained from the licensed fire protection/sprinkler protection vendor for the dry/wet/3wet systems was obtained and placed in the Life Safety Code binder7/20/2026. Identification of other areas The maintenance director/designee conducted a facility wide review of all fire protection system documentation, including, but not limited to, sprinkler inspections, testing reports, and any deficiency corrections. The quarterly reports were located by the maintenance director. The 5-year document was obtained from the license vendor. Any documentation gaps were corrected, and records were organized to be readily available. All other Inspection of sprinklers were documented		08/13/2026

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K0353 SS = F Bldg. 01	Continued from page 3 Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by observation and review of available documentation that there was discontinuity between vendor records and riser hang tag(s). On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that no documentation was presented for review to confirm annual inspection of the facility dry system. On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that no documentation was presented for review to confirm that annual inspection of the facility 3-wet system. On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by observation and review of available documentation that no documentation was presented for review associated to the 5-year system inspections (wet / dry / 3-wet) that were completed in 2025 – per dating observed on riser gauge(s). On 06/16/2026 between 12:30 PM and 3:30 PM, it was revealed by observation in the resident corridor(s) that sprinkler heads adjacent to HVAC ducting were debris loaded. On 06/16/2026 at 2:00 PM, it was revealed by observation in the Kitchen / Stovetop Area(s) that sprinkler head(s) exhibited signs of being grease / debris loaded. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0353	Continued from page 3 and cleaned of debris if necessary. Systemic Changes A Designated Life Safety Code binder containing all sprinkler system reports has been made. Implementation of a vendor spreadsheet/3rd party vendor to ensure proper timing and documentation is conducted. The maintenance director was educated on K353 on 7/15/2026. Monitoring The administrator/Maintenance Director/designee will conduct audits x 3 months of the sprinkles located near the HVAC and kitchen ensuring clearance of debris and proper documentation to verify that required records are present and current. Audit findings will be brought to the Quality Assurance Performance Improvement committee for further review and recommendations. Completion 8/13/2026		08/13/2026
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour			K0372	K372 Subdivision of Building Spaces-Smoke damper Corrective Action for Deficient Practice Upon identification of the deficiency, a qualified Life Safety contractor was engaged to perform a physical verification of all smoke dampers throughout the facility by July 24, 2026.		08/13/2026

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K0372 SS = F Bldg. 01	Continued from page 4 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to properly maintain fire/smoke dampers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 8.4.6.2, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by a review of available documentation that there was conflicting data between the 2022 and 2026 inspection reports (2022 listed 10 dampers inspected / tested – 2026 listed 2 dampers inspected / tested). An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0372	Continued from page 4 The facility's smoke damper inventory was located and revised to accurately reflect the actual number, location, and identification of each smoke damper. Identification of Other Areas Potentially Affected The maintenance director/designee did a complete review of all Life Safety system inventories, including smoke barriers, fire dampers, and smoke dampers, to identify any additional discrepancies between facility records, inspection reports, and Life Safety drawings. Any inconsistencies identified during this review were corrected and updated accordingly. Systemic Changes to Prevent Recurrence The facility has implemented the following measures: A master smoke damper inventory has been established and designated as the official source document. Updated documentation has been maintained in the Life Safety compliance records The Maintenance Director was educated on 7/105/2026 on K372. Monitoring Procedure The Maintenance Director or designee will: Audit the smoke damper inventory and related Life Safety documentation after annual inspection for accuracy. Audits will be brought to Quality Assurance Performance Improvement committee for review and recommendations.		08/13/2026

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K0372 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4*, 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that fire drill records exhibited lack of randomness and patterning. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0372	Continued from page 5 Completion Date 8/13/2026		08/13/2026
K0712 SS = F Bldg. 01				K0712	K712 Fire Drills Corrective Action for Deficient Practice Upon identification of the deficiency, the facility conducted an immediate review of all fire drill documentation for the previous 12 months. Drill times and scenarios were analyzed to identify patterns and trends. A revised fire drill schedule was developed to ensure drills are conducted on varying days, times, shifts, and under varying simulated fire conditions. Identification of Other Areas Having the Potential to Be Affected The Maintenance Director reviewed all fire drill records for each shift to determine whether additional patterning or scheduling concerns existed. Any quarters identified as having repetitive drill times or scenarios were addressed through staff education and implementation of a new scheduling process. Systemic Changes to Prevent Recurrence The facility has implemented the following corrective measures: Fire Drill Matrix has been developed to track drill dates, times, shifts, and scenarios. The Maintenance Director has been educated on K712 requirements regarding varied and unexpected drill conditions ON 7/15/2026.		08/13/2026

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K0712 SS = F Bldg. 01				K0712	Continued from page 6 Monitoring Procedure The Maintenance Director or designee will: Review all completed fire drills monthly for three months to verify compliance with varied and unexpected timing requirements. Report results to the Quality Assurance and Performance Improvement (QAPI) Committee quarterly. Completion Date 8/13/2026		08/13/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview the facility failed to implement door testing documentation per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.			K0761	K761 Maintenance, Inspection and testing of doors Corrective Action for Deficient Practice The Maintenance Director/designee conducted a comprehensive review of all door inspection, testing, and maintenance records. Identification of Other Areas Potentially Affected The Maintenance Director reviewed all door inspection programs throughout the facility to identify additional undocumented inspections, missing records, or inconsistencies between inspection reports and facility inventories. The maintenance was able to locate the missing documentation of door inspections. Systemic Changes to Prevent Recurrence The facility implemented the following measures: A complete inventory of applicable fire doors, smoke barrier doors, and corridor doors was established, and all inspection records were organized into a centralized Life Safety Code binder.		08/13/2026

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K0761 SS = F Bldg. 01	Continued from page 7 Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by a review of available documentation that annual door inspection was last completed 05/2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761	Continued from page 7 The maintenance director was educated on k761 on 7/16/2026. Monitoring Procedure The Maintenance Director or designee will: Conduct monthly audits of door inspection documentation for three months and annually. Report audit findings and corrective actions to the QAPI Committee quarterly. Completion Date 8/13/2026		08/13/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and			K0914	K914 Electrical Systems- Maintenance and testing Corrective Action for Deficient Practice Upon identification of the deficiency, the Maintenance Director conducted a comprehensive review of all electrical outlet testing, and maintenance records. The missing document was located and assessed for required information. Systemic Changes to Prevent Recurrence The maintenance director was educated on K914 documentation requirements on 7/15/2026. Established a centralized Life safety Code binder for all electrical outlet documentation. Monitoring Procedure The Maintenance Director or designee will:		08/13/2026

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K0914 SS = F Bldg. 01	Continued from page 8 staff interview, the facility failed to complete inspection / repair of electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed a review of available documentation that no documentation was presented for review to confirm that corrective actions had been implemented / completed associated with electrical outlet testing of resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0914	Continued from page 8 Audit the electrical maintenance record for compliance 1x per month for 3 months and annually for required information. Results of the audits will be brought to QAPI for review and recommendations. Completion 8/13/2026		08/13/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111,			K0918	K918 Electrical Systems-Essential Electric System Corrective Action for deficient Practice Upon identification of the deficiency, the Maintenance Director conducted a comprehensive review of generator testing and documentation. The maintenance director/designee completed the required testing of the generator and documentation was kept. A qualified vendor was notified of the oil filter documentation and requested to change the oil filter. Systemic Changes to Prevent Recurrence The maintenance director was educated on K914 on 7/15/2026. The maintenance director established a Life safety code binder for all documents required. A camera was placed in the area where the generator annunciator panels are located, and the monitor was placed at the nurse's station. Monitoring Procedures		08/13/2026

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K0918 SS = F Bldg. 01	Continued from page 9 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain remote monitoring per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed a review of available documentation that no documentation was presented for review to confirm that weekly inspections of GEN SET #1 (INTERNATIONAL HARVESTOR) are being conducted and documented 2. On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed a review of available documentation that no documentation was presented for review to confirm that weekly inspections of GEN SET #2 (CUMMINS) are being conducted and documented 3. On 06/16/2026 at 2:40 PM, it was revealed by observation that the emergency generator remote annunciator panel(s) were found located in closed Nurses Station - not accessible or visible for monitoring by facility staff. 4. On 06/16/2026 at 2:50 PM, it was revealed by observation that the emergency generator - GEN SET #2 (CUMMINS) exhibited dating in the oil filter (11/2022). An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918	Continued from page 9 The maintenance director/designee will conduct audits of documentation and monitoring system 1 x week for 4 weeks and 1 x month for 3 months. Results will be reviewed by the Quality Assurance Performance Improvement Committee. Completion 8/13/2026		08/13/2026
K0926 SS = F Bldg. 01	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only			K0926	K926 Gas Equipment How Deficient Practice Was Corrected The facility immediately reviewed all personnel assigned duties involving the medical gas system. How Other Areas with the Potential to Be Affected Were Identified and Corrected		08/13/2026

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K0926 SS = F Bldg. 01	Continued from page 10 by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview the facility failed to provide documentation of education and staff training per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1, 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 6/16/2026 between 9:30 AM and 1:00 PM, it was revealed a review of available documentation that no documentation was presented for review to confirm that initial and continuing education cover safety and risks associated with the handling of Med Gas (O2) cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0926	Continued from page 10 An audit of all facility maintenance personnel, contractors, and individuals who may perform work on medical gas was conducted to ensure qualifications and training records were available and current. All staff that have duties that involve medical gas will be required to take the education from the site education vendor. Systemic changes All staff upon hire will receive the education through the vendor platform. Tracking will be conducted in the vendor platform. The maintenance director was educated on K926 on 7/15/2026. Medical gas training requirements were incorporated into orientation and annual competency reviews as applicable. 4. Monitoring Process The Maintenance Director/designee will: Audit 1 x per month x 3 months personnel qualification and training records for all staff and contractors involved with medical gas systems. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review and recommendations. Completion 8/13/2026		08/13/2026

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K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain proper inspection and safety measures associated with commercial residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9) and NFPA 96 (2014 edition) Standard for Ventilation Control and Fire Protection of Commercial Cooking sections 4.1.5 and 11.2.1. Operations. This deficient finding could have a isolated impact on the residents within the facility. Findings Include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed a review of available documentation that no documentation was presented for review to confirm inspection of the ansul type suppression system is being complete every six (6) months . An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	K324 Cooking facilities Ansul Corrective Action for Deficient Practice The facility contacted its licensed kitchen fire suppression vendor. Copies were requested for the Ansul system inspection. Any missing inspections are scheduled for 7/22/2026. Identification of Other Areas Potentially Affected An audit of vendor records for the kitchen ansul system was conducted including but not limited to hood cleaning: Any missing or incomplete records identified during the audit were obtained and filed appropriately. Systemic Changes to Prevent Recurrence A compliance binder for Life Safety Code was created to maintain documentation A calendar reminder system/vendor was implemented to track recurring inspection due dates. The Maintenance Director was educated regarding documentation retention and survey readiness requirements on 7/15/2026. Monitoring The Maintenance Director or designee will: Audit Ansul system documents 1 x per every 3 months, x 9 months. Audit will be reported to the Quality Assurance and		08/13/2026

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K0324 SS = D Bldg. 01				K0324	Continued from page 12 Performance Improvement (QAPI) Committee quarterly for review and recommendations. Completion 8/13/2026		08/13/2026
K0355 SS = C Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to properly maintain fire extinguisher documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2.1.2, 7.2.4, 7.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/16/2026 between 10:00 AM and 3:30 PM, it was revealed by a review of available documentation that no annual vendor fire extinguisher inspection documentation was available for review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0355	K355 portable fire extinguisher documentation Corrective Action for Specific Deficiency The Maintenance Director immediately reviewed all portable fire extinguisher records. Missing inspection, annual maintenance, and service documentation was obtained from the contracted fire protection vendor and filed in the Life Safety Code compliance binder. Any extinguisher found without current documentation was verified for compliance and serviced as necessary. Identification of Other Areas Potentially Affected A facility-wide audit of all portable fire extinguisher documentation was conducted to verify: Annual maintenance records were current. Vendor service tags matched documentation on file. Any missing or incomplete records identified during the audit were corrected immediately. Systemic Change The maintenance director was educated on K355 on 7/15/2026.A Portable Fire Extinguisher Documentation Log was implemented. Annual vendor inspection reports will be reviewed		08/13/2026

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K0355 SS = C Bldg. 01				K0355	Continued from page 13 upon receipt and filed in the Life Safety compliance binder. A documentation tracking calendar/vendor platform was established to monitor due dates for inspections and maintenance activities. Monitoring The Maintenance Director or designee will conduct: Audits of fire extinguisher documentation 1 x every 3 months and 1x per year. Required annual maintenance documentation is present. Service tags and documentation are consistent. Audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee. Completion 8/13/2026		08/13/2026