Electronically Delivered

November 4, 2022

Administrator
St Mark's Heritage Community
400 15th Avenue Southwest
Austin, MN 55912

RE: Project Number(s) SL30839015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 12, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30839015 On October 10, 2022, through October 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 38 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 640	Continued From page 2	0 640		
0 640	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by failing to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). The findings include: On October 10, 2022, at 11:00 a.m. the surveyor toured the facility with registered nurse (RN)-B	0 640		

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0 640	Continued From page 3 and resident services coordinator (RSC)-F, noting the main entrance and/or common areas lacked the required posting for 911. RSC-F indicated they had 911 posted on the second floor in the stairwells. Just inside the second-floor stair well, the wall included a telephone jack for a wall mounted phone and tape indicating a sign was above the telephone jack. RSC-F and RN-B confirmed the sign was no longer posted. On October 10, 2022, at 3:00 p.m. the surveyor found no evidence of a 911 posting in the secondary stairwell. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 4 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-E and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E ULP- E was hired on September 6, 2019, to provide to provide direct care services to residents of the facility. ULP-E's record lacked documentation of a	0 650		

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0 650	Continued From page 5 completed performance evaluation. On October 11, 2022, at 2:00 p.m. registered nurse (RN)-B confirmed ULP-E has not had any performance evaluations. RN-B further stated some employees have had a performance evaluation, but not all. ULP-G ULP-G was hired on May 31, 2021, to provide direct care services to residents of the facility. ULP-G's training record lacked documentation of completed training to include all required training and competencies. On October 11, 2022, at 2:45 p.m. RN-B along with resident services coordinator (RSC)-F, stated the nurse who did the training was no longer here. That nurse did everything on paper and they cannot find the documentation for ULP-G. RSC-F stated she remembered ULP-G being trained in by the nurse as she was the one who scheduled the training. New employees were not allowed on the floor to work or pass medications until they had been competency tested. RSC-F stated she spoke with the nurse who did the training and competencies with ULP-G, and she did not know where the paperwork is. On October 12, 2022, at 1:00 p.m. ULP-G stated the nurse trained her to administer medications including insulin, and she had to perform a return demonstration. The licensee's Training Documentation policy dated August 1, 2021, indicated staff training will be documented completely and correctly.	0 650		

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0 650	Continued From page 6 The licensee's Personnel Records policy dated August 1, 2021, indicated the personnel record for each person will include record of all required training for unlicensed personnel and competency evaluation and performance evaluations which identify areas of improvement needed and training needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 7 for Disease Control and Prevention (CDC) which included baseline testing for two of two employees (unlicensed personnel (ULP)-E and ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's TB facility risk assessment dated April 20,2022, indicated the facility was a low risk. ULP-E ULP- E was hired on September 6, 2019, to provide to provide direct care services to residents of the facility. ULP-E's employee record included a TB history and symptom screen dated September 10, 2019, and a TST (tuberculin skin test) which was placed September 10, 2019, with the reading on September 12, 2019. The TB skin test was negative with 0 mm (millimeter) induration. A second step TST was not completed as required. ULP-G ULP-G was hired May 31, 2021, to provide direct cares for residents of the facility. ULP-G's employee record included a TB history and symptom screen dated June 1, 2021, and a TST which was placed June 7, 2021, with the reading on June 9, 2021. The TB skin test was	0 660		

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0 660	Continued From page 8 negative with 0 mm induration. A second step TST was not completed as required. On October 11, 2022, at 3:35 p.m. human resources director (HRD)-H stated ULP-G was hired during COVID when they were not doing a second step, and she was not sure why ULP-E did not have the second step done. HRD-H stated she did not know they had to go back and compete the second step. Their normal practice was for every new employee to get both steps of the TST. HRD-H stated she had not audited the employee files for TST screenings but will. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated prior to contact with clients, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay (IGRA) for M. tuberculosis will be administered. If the first step of the two-step TST is negative the employee may begin working with clients but must have the second TST test within 21 days after hire. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.	0 660		

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0 660	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 10/12/2022 between 01:30 PM to 03:00 PM, survey staff observed during the	0 800		

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0 800	Continued From page 10 walk-through of the structure that on the 1st FL - Nurses Station storage and extension cord was in use 2. On 10/12/2022 between 01:30 PM to 03:00 PM, survey staff observed during documentation review that on the 1st FL - Commons West, in the furnace room closet, the ceiling recessed sprinkler head was obstructed 3. On 10/12/2022 between 01:30 PM to 03:00 PM, survey staff observed during the walk-through of the structure that on the 2nd FL - RM 269, the use of a 1-3 electrical outlet adapter and a 2-6 electrical outlet adapter ED-D verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 11 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 10/12/2022 between 01:30 PM to 03:00 PM, survey staff observed that no documentation	0 810		

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	30839	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 was presented during documentation review to confirm that staff are conducting evacuation drills ED-D verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 13 The findings include: During the entrance conference on October 10, 2022, at 10:40 a.m. the surveyor asked for a copy of the assisted living contract. The assisted living contract provided included a clause the indicated the resident will hold the facility harmless. Page 12, section 31, Resident will indemnify and hold harmless the Community, its employees and agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the Apartment or any other part of the Community's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. On October 12, 2022, at 12:00 p.m. licensed assisted living director (LALD)-A confirmed the standard contract included an indemnification clause, and the contracts were just amended to remove a waiver of liability and sent out to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 14 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with	01060		

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01060	Continued From page 15 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 started receiving services on June 8, 2022. R4's service plan dated June 10, 2022, indicated R4 received assistance with activities of daily living (ADL), medication administration, housekeeping, and laundry. R4 was admitted to the hospital on July 23, 2022, after a fall causing a pelvic fracture. R4's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

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01060	Continued From page 16 information for the agency to which the resident may submit an appeal. R4's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On October 12, 2022, at 10:30 a.m. registered nurse (RN)-B and resident services coordinator (RSC)-F stated they were familiar with this requirement and confirmed R4's record should have contained but did not show evidence of the notification. The licensee's Resident Emergency Relocation standard operating procedure (SOP) last revised March 2, 2022, indicated the Emergency Relocation Notice must be delivered to the resident, legal representative, designated representative, and the office of the Ombudsman. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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01440	Continued From page 17 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure a registered nurse (RN) conducted direct supervision of one of one unlicensed personnel (ULP-G) performing a delegated task within 30 days of providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G had a hire date of May 31, 2021. ULP-G's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work	01440		

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01440	Continued From page 18 was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On October 10, 2022, at 3:30 p.m. the surveyor observed ULP-G administer medication for R7. On October 12, 2022, at 10:30 a.m. registered nurse (RN)-B stated the 30-day supervision was likely not completed for ULP-G. Currently, the 30-day supervisions are in the electronic system, and it is flagged for the nurse to complete. They were in the process of going through the charts and making sure everyone was caught up. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated supervision of ULP's by an RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 19 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 for two of three residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The Findings Include: R3 R3 began receiving assisted living services on May 25, 2022.	01620		

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01620	Continued From page 20 R3's service plan dated May 25, 2022, indicated R3 received services to include assistance with medication administration and activities of daily living (ADLs), housekeeping and laundry. R3's record included an initial assessment dated May 25, 2022, and a reassessment dated June 28, 2022, which was 31 days after the start of services (17 days late). R4 R4 began receiving assisted living services on June 8, 2022. R4's service plan dated June 10, 2022, indicated R4 received services to include assistance with medication administration, ADLs, laundry and housekeeping. R4's record included an initial assessment dated June 8, 2022, and a reassessment dated June 28, 2022, which was 20 days after the start of services (6 days late). On October 12, 2022, at 10:17 a.m. RN-B confirmed R3 and R4's record did not contain the required 14-day assessment after admission. RN-B stated she was aware they were missing assessments due to a recent audit of files after the previous nurse left. The licensee's Initial and On-going Nursing Assessment of Residents policy dated August 1, 2021, indicated a 14-day assessment is completed up to 14-days after start of services. No further information was provided.	01620		

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01620	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
02110 SS=D	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and	02110		

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02110	Continued From page 22 designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked evidence the resident or residents' representative were provided the additional required policies and procedures for assisted living facilities with dementia care. On October 12, 2022, at 10:30 a.m. registered nurse (RN)-B stated upon admission residents or their representative received copies of the required dementia policies, but she did not have the signature page showing the receipt of the required policies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/11/22*
Time: 07:24:06
Report: 8044221360

Food and Beverage Establishment Inspection Report

Location:
St Mark'S Heritage Community
400 15th Avenue Sw
Austin, MN55912
Mower County, 50

Establishment Info:
ID #: 0038382
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074347237
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Sign not posted at handwashing sink in kitchen.

Comply By: 10/12/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Upright cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

HRD inspection conducted with lead surveyor Tracey Fearon and Wendy Robarge.

Inspection report reviewed on site with Tammy.

Type: Full
Date: *10/11/22*
Time: 07:24:06
Report: 8044221360
St Mark'S Heritage Community

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044221360 of 10/11/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Inspector signed for Tammy

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us