



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 28, 2025

Administrator
St. Marks Living
400 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: February 21, 2025

Dear Administrator:

On March 13, 2025, we notified you a remedy was imposed. On May 20, 2025, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 22, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2025 be discontinued as of May 22, 2025. (42 CFR 488.417 (b))

In our letter of March 13, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 21, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 22, 2025

Administrator
St. Marks Living
400 15th Avenue Southwest
Austin, MN 55912

RE: CCN: 245369
Cycle Start Date: February 21, 2025

Dear Administrator:

On March 13, 2025, we informed you of imposed enforcement remedies.

On March 31, 2025, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2025. (42 CFR 488.417 (b))

On April 3, 2025, the Minnesota Departments of Health and Public Safety completed a standard recertification survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 21, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 21, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

An equal opportunity employer.

As we notified you in our letter of March 13, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 21, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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

St. Marks Living

April 22, 2025

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Minnesota Department of Health

12 Civic Center Plaza, Suite #2105

Mankato, Minnesota 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 21, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 05/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 3/31/25-4/3/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000			
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004			5/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2025

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

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E 004	Continued From page 1 and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Emergency Preparedness program (EPP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 36 residents currently residing in the facility and all staff and visitors to the facility. Findings include:	E 004	E004 The Administrator/designee reviewed and updated the facility's emergency preparedness policies and procedures to ensure they are comprehensive, hazard-specific, and align with the facility's Emergency Plan. The revisions were completed on 4/4/2025 and the signature was updated to reflect revisions.		

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E 004	Continued From page 2 A review of the facility's emergency preparedness plan was conducted on 4/2/25 at 11:30 a.m., the emergency plan lacked documentation of the annual review of the program and associated policies and procedures. The last documented date of reviewed was listed as 5/22/23. During an interview on 4/2/25 at 11:50 a.m., the administrator stated she started her position in June 2024 and has not reviewed the emergency plan since that time. A new risk assessment was completed but the policies and procedures and emergency plan have not been evaluated. The administrator reviewed the resident data and emergency contacts in the plan and confirmed the information is outdated.			E 004	All residents in the facility could potentially be affected by a lack of appropriate emergency policies. A comprehensive review of emergency protocols for all residents was conducted to ensure their needs would be met during an emergency. Staff were updated on any revised policies. The administrator/designee conducted a full audit of all emergency policies. The emergency Plan will be audited at minimum annually. The date was placed on the facility calendar. The QA Committee will review emergency preparedness policies quarterly for accuracy and completeness. Emergency drills will be conducted at least twice annually, and feedback will be incorporated into further revisions of policies.		
F 000	INITIAL COMMENTS On 3/31/25-4/2/25, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. 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.			F 000			

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F 000	Continued From page 3 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.	F 000			

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

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F 000	Continued From page 4	F 000			

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F 000	Continued From page 5	F 000			

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8OJN11 Facility ID: 00394 If continuation sheet Page 7 of 47

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F 000	Continued From page 7 of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656			5/9/25

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F 656	Continued From page 8 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed to include of post-traumatic stress disorder (PTSD) triggers and interventions for 1 of 1 resident (R25) who had a diagnosis of PTSD. R25's admission Minimum Data Set (MDS) assessment dated 2/12/25, indicated moderately impaired cognition, feeling down, depressed or hopeless nearly every day, dependent on staff for personal hygiene, dressing, toileting, utilized a			F 656	F656 1. Resident R25's care plan was immediately evaluated by the Interdisciplinary Team (IDT) and revisions were made to include the resident PTSD diagnosis, identified triggers, and appropriate interventions. 2. The IDT team reviewed all residents with the diagnosis of PTSD and updated any care plan to ensure they included identified triggers and corresponding interventions.		

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F 656	Continued From page 9 walker and wheelchair, diagnoses included psychotic disorder and post-traumatic stress disorder (PTSD), and antipsychotics were received on a routine basis. R25's care plan dated 2/28/25, indicated medications daily for PTSD, psychosis, monitor/record occurrence of target behaviors: worried expression, verbalization of worries. monitor/record target behaviors: restlessness, wandering, pacing, exit seeking, unable to sit still to rest, administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, consult with pharmacy, medical doctor (MD) to consider dosage reduction when clinically appropriate at least quarterly, discuss with MD, family ongoing need for use of medication, review behaviors/interventions and alternate therapies attempted and their effectiveness. R25's annual Care Area Assessment (CAA) dated 2/12/25, triggered for Psychosocial Well-Being R25's mood interview indicates the presence of little interest or pleasure in doing things, when assessed, the resident was asked if he had little interest in doing anything, and he stated yes for 2-6 days, has been feeling down for 12-14 days due to everything happening to him, trouble falling asleep at night for 2-6 days and feeling tired for	F 656	3. A mandatory education session was held with all IDT members for the identification of PTSD diagnosis and the person-centered care plans. On April 14, 2025, a mandatory education was completed. 4. The Director of Nursing (DON) or designee will audit upon admission and change of condition with diagnosis of PTSD for resident centered interventions and triggers.		

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OMB NO. 0938-0391

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F 656	Continued From page 10 2-6 days due to being unable to sleep at night, history of delusional disorders and unspecified psychosis. R25's Psychosocial Assessment dated 2/6/25, indicted sometimes traumatic events in a person's life can have an effect on how we heal from illnesses or react to certain situations now, would you like to discuss interventions that may help address these concerns, response indicated no. On 3/31/25 at 1:58 p.m., R25 stated he had PTSD and some things that triggered his PTSD were flashbacks of his mom getting beat up, staff that were not patient, when staff made him wait a long time for help, voices and loud noises across the hall at night. On 3/31/25 at 7:01 p.m., registered nurse (RN)-B stated R25 had brain trauma and was not sure if R25 had a diagnosis of PTSD. On 3/31/25 at 7:04 p.m., R25 was laying in bed and stated he mainly stays in his room all day and will leave his room to go to therapy appointments, does not like to participate in group activities. R25 further stated I am in this "hole all day long", and "I wish people would come and talk and visit". R25 stated there is a list of activities to do, but I don't want to do those. R25 stated nobody comes to visit with me unless they are checking my catheter bag and stated wished people that worked here would come visit with me and not ignore me, because I feel like I am just staring and talking to a wall all day. On 4/1/25 at 9:18 a.m., RN-A, known as the nurse manager, stated R25's PTSD triggers were	F 656			

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F 656	Continued From page 11 expected on his care plan. RN-A stated R25's care plan discussed PTSD medications and side effects of medications, and confirmed R25's care plan lacked the PTSD triggers and interventions. RN-A stated she completed residents' assessments, and stated the director of nursing was responsible for updating the care plans. On 4/1/25 at 9:59 a.m., social services (SS)-A stated the MDS coordinator was responsible for updating the care plans. On 4/1/25 at 11:51 a.m., SS-A stated she visited and with R25 and will use the trauma assessment for triggers and interventions on R25's care plan related to PTSD. On 4/1/25 at 12:40 p.m., the director of nursing (DON) stated the admission nurse was responsible for completing the care plan at the time of resident's admission. Facility Care Plans, Comprehensive Person-Centered policy dated 3/11/20, indicated: The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment The comprehensive, person-centered care plan will: Include measurable objectives and timeframe's; Describe the services that are to be furnished to attain or maintain the resident ' s highest			F 656			

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F 656	Continued From page 12 practicable physical, mental, and psychosocial well-being; Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; Describe any specialized services to be provided as a result of PASARR recommendations; Include the resident ' s stated goals upon admission and desired outcomes; Include the resident ' s stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; Incorporate identified problem areas; Incorporate risk factors associated with identified problems Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. No single discipline can manage an approach in isolation. The resident ' s physician (or primary healthcare provider) is integral to this process. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive	F 656			

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F 656	Continued From page 13 assessment (MDS). Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. The Interdisciplinary Team must review and update the care plan: When there has been a significant change in the resident ' s condition; When the desired outcome is not met; When the resident has been readmitted to the facility from a hospital stay; and At least quarterly, in conjunction with the required quarterly MDS assessment.	F 656			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physician orders were followed for pressure ulcer (PU) wound care for 1 of 1 resident (R2) reviewed for pressure ulcers.	F 686	F686 1. Resident R2 dressing change was done immediately completed per physician order by staff nurse. Staff involved were educated on following physician orders for wound care	5/9/25	

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F 686	Continued From page 14 Findings include: R2's facesheet printed on 4/3/25, included diagnoses of palliative care, Alzheimer's disease, and pressure ulcer sacral region. R2's annual Minimum Data Set (MDS) assessment dated 2/25/25, indicated severe cognitive impairment, dependency on staff for all activities of daily living, and two unstageable pressure ulcers. R2's care area assessment (CAA) dated 2/25/25, triggered secondary to actual pressure ulcers. Contributing factors included mobility impairment, actual pressure ulcers, cognitive loss, incontinence, and pain. Risk factors included pain, wound infection, and fluid deficit risk. R2's physician orders dated 3/31/25, included: --LEFT HIP: cleanse pressure injury with wound cleanser. Pat dry. Open and sprinkle Flagyl (an antibiotic) 375 mg (milligrams) capsule to wound base with dressing change. Pack with moistened packing strip. Apply foam border dressing to cover. Change daily and prn, every night shift for wound care (possible wound infection) AND as needed for wound care. --COCCYX: cleanse wound with wound cleanser. Open and sprinkle 1 Flagyl 375 mg capsule on wound bed. Pack with moistened packing strip. Apply foam border dressing to cover. Change daily and PRN if soiled every night shift for Wound Care AND as needed for Wound Care R2's care plan with revised date of 6/8/23, indicated R2 was at risk for pressure ulcer formation related to her bowel/bladder incontinence, low weight/bony prominence's, and	F 686	interventions. Resident continues to receive wound care per updated physician orders 2. All residents identified with pressure ulcers were reviewed to ensure physician orders for wound care are being followed. Nursing staff were educated on following wound care orders and the facility's dressing change policy. 3. Dressing change policy education was conducted with all licensed nursing staff on 04/30/2025. All wound dressing changes will be audited 20% of dressing changes audited five (5) days per week for one (1) month, 20% of dressing changes audited three (3) days per week for one (1) month, 20% of dressing changes audited quarterly. 4. The Director of Nursing (or designee) will track audit results. Audit outcomes will be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meetings for review and recommendations.		

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F 686	Continued From page 15 decreased mobility. Care plan intervention dated 3/31/22, indicated staff would provide treatments as ordered for sacrum and right hip. During an observation on 4/2/25 at 1:09 p.m., with licensed practice nurse (LPN)-A, viewed R2's pressure wounds to her sacrum and left hip. LPN-A stated dressing changes were done daily on the night shift. LPN-A removed the foam dressing from the left hip, had a scant amount of serosanguinous drainage on it and measured 8.0 centimeters (cm) x 5.5 cm. LPN-A reapplied a foam dressing to the wound. LPN-A removed the dressing from the sacral PU, and it had a moderate amount of serosanguinous drainage on it and measured 3.0 cm x 3.5 cm, no redness or bone visible. LPN-A reapplied a foam dressing to the wound. During record review after observing the wounds and dressing changes, noted the physician order indicated both wounds were to be packed with saline moistened packing strips. When LPN-A removed the dressing that had been applied by the night shift nurse, there were no packing strips observed either in or on the wounds or on the dressings she removed, nor did LPN-A place moistened packing strips in the wounds as ordered by the physician when she replaced the dressings. During an interview on 4/2/25 at 2:02 p.m., registered nurse (RN-A) who was also the nurse manager stated she was not aware of the order to pack R2's wounds with moistened packing strips, stating she would need to look at the order. After reviewing the order, RN-A verified the ordered included packing strips to both wounds. Together with RN-A, went to R2's room to see if there were			F 686			

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F 686	Continued From page 16 packing strips and saline available and there was, but no disposable sterile tweezers to use to pack the wounds. RN-A stated that would be necessary to pack the wounds. RN-A admitted she did not oversee wound care orders, observe wounds or dressing changes -- only if asked to by nursing staff. During an interview on 4/2/25 at 2:10 p.m., RN-C who was R2's hospice nurse stated hospice was in charge of wound management for R2. RN-C stated the order for wound care with saline moistened packing strips was not a new order, but it had been modified several times. Looking at previous hospice orders, RN-C stated the wound orders for hip and sacrum, including packing both wounds with moistened packing strips started on 1/31/25. During an interview on 4/2/25 at 2:27 p.m., the director of nursing (DON) joined the conversation with RN-A and RN-C and stated the process of informing nurses of new orders depended on the time of the day and whether the HUC (health unit coordinator) or a nurse entered the provider orders into the EMR. In any case, the DON stated the orders were on the TAR (treatment administration record) and nurses were expected to review them before going into a residents room. The DON stated the nurse who changed the dressing on the night shift and who did not follow physician orders for packing the wounds with saline moistened packing strips, was RN-D. The DON stated she would contact her about it. During a telephone interview on 4/2/25 at 2:34 p.m., with LPN-A, and with the DON and RN-A present, LPN-A admitted she forgot to use the packing strips to pack R2's wounds when she	F 686			

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F 686	Continued From page 17 changed the dressing with the surveyor observing. LPN-A stated before she ended her shift, she changed the dressings and packed the wounds. In addition, LPN-A stated when she changed the dressing, she sprinkled the Flagyl on top of the packing strip, to which RN-A stated, the order was for the Flagyl to be sprinkled on the wound bed (not on top of the packing strips). During an interview on 4/2/25 at 3:07 p.m., the DON stated she called and left a message for RN-D who changed the dressing on the night shift on 4/2/25. In addition, the DON stated she had been planning to ask hospice to provide wound management training and would now get it scheduled. In a follow-up via email on 4/3/25 at 2:37 p.m., RN-D confirmed to the DON she had changed R2's dressing during the night on 4/2/25, and did not read R2's wound care orders carefully, and therefore did not pack the wounds with moistened packing strips as ordered by the physician. Facility Dressing Change/General Wound Care policy with review date of 4/2025, indicated all dressing changes would be performed by licensed nursing staff in accordance with provider orders, evidence-based practice, infection control protocols, and resident specific care plans. All dressing changes would be documented in the residents medical record. Steps included: Verify orders by checking the most current provider order for dressing change frequency, type of dressing, and any special instructions.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688			5/9/25

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F 688	Continued From page 18 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R7) reviewed for limited ROM. Findings include: R7's facesheet printed on 4/3/25, included diagnoses of multiple sclerosis (MS), osteoporosis, diabetes and heart disease. R7's annual Minimum Data Set (MDS) assessment dated 3/18/25, indicated R7 was cognitively intact, had clear speech, could understand and be understood. R7 was dependent upon staff for most ADL's and did not walk. The MDS did not indicate that R7 was in a restorative nursing program.			F 688	F688 1. Resident R7 was immediately reassessed by therapy and nursing. Restorative therapy services were initiated to address range of motion (ROM) needs. Care plan and interventions were updated to reflect ROM treatment goals and services. 2. All residents identified with limited ROM were reviewed to ensure restorative programs were in place. Resident care plans that were identified to have limited range of motion were updated to reflect interventions. 3. Education on the Restorative Therapy Program was provided to leadership and all direct care staff completed on 04/24/2025. Direct care staff were educated on a 5 min meeting on all shifts		

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F 688	Continued From page 19 R7's orders dated 5/9/23, indicated PT evaluation. R7's care plan dated 8/4/21, indicated R7 had an alteration in musculoskeletal status related to history of MS, would remain free of complications or discomfort related to MS, and would have range of motion (active or passive) with am/pm (morning and evening) care daily. R7's care plan dated 11/24/21, indicated R7 had limited physical mobility related to MS with referrals to PT and OT, and to monitor/document/report PRN (as needed) any signs and symptoms of contractures forming. During an interview on 3/31/25 at 1:12 p.m., R7, who was sitting in her electric wheelchair stated she was not able to walk or move her legs, and stated she did not receive passive ROM to them. R7 stated leg exercises had only been done when she was in rehabilitation therapy and was no longer in therapy. R7 stated she would like leg exercises to keep her joints limber, adding...but I know the nurses are busy. During an interview on 4/1/25 at 11:51 a.m., physical therapy aide (PTA)-G, provided a paper document titled Therapies Restorative Care Program. The document indicated R7 had started active PT on 9/3/24, and was discharged from therapy on 10/21/24, with the following restorative nursing recommendations: --Leg lifts 10 reps (repetitions), R LE PROM (right lower extremity passive range of motion) --Kick outs, 10 reps, L LE AAROM to AROM with gentle knee stretch (left lower extremity active, assisted range of motion to active range of motion)	F 688	on 04/28/2025 and again in a meeting on 04/30/2025. A written Restorative Therapy Policy and Procedure was developed and distributed. Certified Nursing Assistants (CNAs) responsible for performing and documenting restorative interventions were educated on the proper documentation procedures for restorative programs. 4. Residents with limited range of motion will be assessed by the IDT team weekly for the need of restorative nursing. The IDT team will audit new admission, change of condition, and quarterly for resident function.		

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F 688	Continued From page 20 --R ankle PROM (right ankle passive range of motion) --L LE AROM (left lower extremity active range of motion) During an interview on 4/1/25 at 11:58 a.m., PTA-G stated she had filled out the Therapies Restorative Care Program form for R7 after R7 had completed physical therapy. PTA-G stated the intent of the form was for nursing to continue the recommendations after R7 was discharged from therapy. PTA-G stated the form was given to the health unit coordinator (HUC)-D and a copy was placed in the restorative nursing binder on the nursing unit. PTA-G stated she also demonstrated to nurses and nursing assistants how to do the exercises since R7 could not do them on her own. PTA-G stated she could not recall if the document was given to the HUC or placed in the binder for sure, but that was their process. PTA-G could not recall which nurse and/or NA she demonstrated the exercises for R7. The Therapies Restorative Care Program form did not indicate who the form was routed to or when. During review of the restorative nursing binder, located at the nurses station, the binder was titled, Occupational and Physical Therapy Resident Updates. The only document in the binder for R7 was not related to restorative nursing. During an interview on 4/1/25 at 2:28 p.m., nursing assistant (NA)-B stated R7 did not receive restorative nursing services. NA-B stated if a resident received restorative nursing services, it would be noted on the TASK list in the electronic medical record (EMR).	F 688			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
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F 688	Continued From page 21 Review of the TASK list in the EMR for R7 indicated: RESTORATIVE: T-Band pulleys 3x/week. There was nothing on R7's TASK list regarding restorative ROM to her legs. During an interview on 4/02/25 at 9:33 a.m., the director of nursing (DON) and registered nurse (RN)-A, were shown the Therapies Restorative Care Program form for R7, and both stated they had never seen the form before...specifically for R7. RN-A stated therapy would usually place these forms on her desk and then she would add it to the NA care sheets. The DON stated when this recommendation from therapy would have been received in September 2024, R7 would have been able to participate in the recommended ROM exercises. Both the DON and NA-A stated had they received the recommendations, they would have initiated them, but neither could recall receiving it. A restorative nursing policy was requested and not received. In an email follow-up on 4/3/24, the DON indicated they did not have a restorative nursing policy.	F 688			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690			5/9/25

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F 690	Continued From page 22 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and follow provider orders for removal of an indwelling urinary catheter as soon as possible to restore urinary continence for 1 of 1 resident (R25) reviewed for catheter care. Findings include R25's admission Minimum Data Set (MDS) assessment dated 2/12/25, indicated moderately impaired cognition, indwelling urinary catheter,	F 690	F690 1. Resident R25's orders were immediately evaluated, and voiding trial was completed on 04/01/2025. R25's care plan was updated to reflect current bladder management strategy based on clinical condition. 2. Orders for all residents identified with a catheter were reviewed to ensure the physician orders for the catheter were being followed. Health unit coordinator was educated on checking that all		

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F 690	Continued From page 23 dependent on staff for personal hygiene, dressing, toileting, utilized a walker and wheelchair, diagnoses included benign prostatic hyperplasia (enlarged prostate), psychotic disorder, post-traumatic stress disorder, retention of urine, and history of falling. The MDS indicated a toileting program (e.g., schedule toileting, prompted voiding, or bladder training) had not been attempted. R25's care plan dated 2/28/25, indicated R25 had a catheter d/t (due to) urinary retention, catheter care and treatment per current orders, monitor/record/report to MD (medical doctor) for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, position catheter bag and tubing below the level of the bladder monitor and document intake and output as per facility policy. Urology office visit note dated 2/28/25, physician assistant (PA)-C recommend a void trial when due for catheter exchange, if R25 is not able to pass a voiding trial, should continue with his indwelling catheter including routine care and monthly exchanges, if R25 requires chronic catheter, should be seen in one year for follow-up, if catheter able to be removed, should return in three months for follow-up. R25's treatment administration record dated 3/1/25-3/31/25, indicated change Foley collection bag weekly and as needed every Saturday.	F 690	resident visit orders are uploaded in the EMR and Nurse management was educated on checking all visit orders to ensure they are being entered into EMR. 3. All nursing staff were educated on the importance of following provider orders thoroughly on 04/30/2025. Health Unit Coordinator was educated on the importance of obtaining visit notes and orders from that visit within 24-48 hours if not sent with them on 04/01/2025. Nurse management was educated on the importance of checking after visit notes and orders on 04/01/2025. 4. The Director of Nursing, or designee will audit 20% of residents with catheters weekly for four (4) weeks, then Monthly for three (3) months, then 20% quarterly, and any new admissions or change of condition. 5. Results will be brought to the Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations.		

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F 690	Continued From page 24 R25's physician orders, care plan, and progress notes lacked evidence of an order for monthly catheter exchange or voiding trial, and R25's record lacked appropriateness of continued catheter use or justification of continued use. On 3/31/25 at 7:04 p.m., R25 was observed with urinary catheter bag attached to the bed rail. R25 stated he came to the facility with the catheter. R25 stated staff had not offered or attempted to remove the catheter since he was admitted to the facility. R25 stated he recently saw a doctor about the catheter and stated the doctor discussed the facility would attempt to remove the catheter. R25 stated removal of the catheter had not been attempted, and he wished the catheter was removed. On 3/31/25 at 7:09 p.m., registered nurse (RN)-B stated R25 was admitted with a urinary catheter and was not aware if a voiding trial had been attempted. RN-B stated she was not aware of any provider orders for urinary catheter removal and stated the nursing assistants take care of the catheter and stated she had never completed a catheter exchange for R25. On 4/1/25 at 8:39 a.m., the director of nursing (DON) stated when a resident returns from a provider appointment the health unit coordinator (HUC)-A was responsible to enter orders into the electronic medical record (EMR) the resident returned with from the provider visit. The DON stated if the resident did not return with hard copy orders, the HUC was responsible to obtain the orders from the provider or look into resident's provider's EMR from the provider visit. The HUC then was responsible to print the orders, enter the orders in the facilities EMR, and give the orders	F 690			

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F 690	Continued From page 25 to RN-A (nurse manger) to double check the orders. On 4/1/25 at 9:18 a.m., RN-A, also known as the nurse manager, stated R25 saw urology last month, and confirmed the 2/28/25, urology provider note indicated a voiding trial attempt at the next catheter change. RN-A confirmed R25's orders failed to indicate a monthly catheter exchange or voiding trail was entered into R25's EMR. RN-A further confirmed R25 had not had a monthly catheter exchange since admitted to the facility on 2/6/25, and confirmed a voiding trail had not been attempted per the provider order on 2/28/25. RN-A stated she would not have known about the R25's voiding trial order or the catheter exchange order was missing if the state agency (SA) had not brought urology order to the attention of the facility. RN-A stated monthly exchanges of R25's catheter were expected and she assumed were done routinely by nursing staff. RN-A stated the process for entering orders included the HUC-A obtained the resident orders from the provider visit, entered the orders into the EMR, and the orders get placed in the nursing station for the floor nurse to double check the resident order, and the HUC was to verbally tell her (RN-A) of any new resident orders. RN-A stated she was not made aware of any new orders from R25's 2/28/25, urology visit. RN-A confirmed the voiding trial order and catheter exchange order was missed and not placed in the EMR as expected. RN-A confirmed R25 was expected to have had voiding trial ordered and completed. RN-A stated the current process for entering and confirming orders was not working. On 4/1/25 at 9:47 a.m., HUC-A stated her role was to ensure all forms of provider orders	F 690			

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F 690	Continued From page 26 including, physical written forms and electronic visits were printed, entered in the resident's EMR, scanned to the EMR, placed into the nursing station for the nurse to double check the entered orders, and verbally make RN-A aware of new orders. HUC-A stated the orders were not initialed, dated or reviewed by the nurse prior to scanning the order into the EMR. HUC-A stated she was responsible to ensure R25's 2/28/25, urology orders were entered and confirmed R25's voiding trail or monthly catheter exchange was not entered into the EMR as expected. HUC-A stated the order for a catheter exchange was not double checked by a nurse since it was not a pharmaceutical order. HUC-A stated she was not sure if RN-A had been made verbally aware of the R25's new urology orders. On 4/1/25 at 12:40 p.m., the DON confirmed R25's 2/28/25, provider order for trial of catheter removal was expected entered the day or the next day after R25's appointment to be assessed as soon as possible for removal of the catheter to help restore continence. The DON confirmed R25's order for catheter trial removal was not entered into the EMR as expected and trial of the urinary catheter was not attempted as ordered by the provider. On 4/2/25 at 7:36 a.m. R25 was lying in bed and stated his catheter was removed last night and stated he was urinating with no problems or concerns. R25 further discussed having the catheter out was nice and he wished he could have had it [catheter] out sooner. Facility Indwelling Catheter Policy dated 1/25, indicated: 2. Change the drainage bag and connection			F 690			

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F 690	Continued From page 27 tubing bimonthly. 3. Residents with chronic in-dwelling catheters should have Foley catheter replaced according to Physician's order. Documenting in Resident's chart: 1. Identification and documentation of clinical indications for the use of a catheter; as well as criteria for the discontinuance of the catheter when the indication for use is no longer present. 2. Documentation of the involvement of the resident/representative in the discussion of the risks and benefits of the use of a catheter, removal of the catheter when criteria or indication for use is no longer present, and the right to decline the use of the catheter. Facility Policy titled Electronic Health Record (EHR) Maintenance and Documentation Policy dated 3/25, indicated: All resident documents, including admission forms, assessments, progress notes, physician orders, laboratory results, provider visits, hospital visits and care plans, must be uploaded into the EHR promptly, if it is not otherwise charted in the EHR. Health unit coordinator is responsible for this. Health unit coordinator will obtain the necessary records from the visit and give them to the nurse manager to look over, initial, and date. The HUC will then upload necessary information into the EHR. Authorized personnel must ensure scanned or electronically uploaded documents are legible, properly indexed, and accurately linked to the correct resident record. The facility will utilize automated interfaces where possible to reduce manual data entry errors. Paper records, when necessary, must be scanned into the EHR within 24 hours of receipt.	F 690			

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F 690	Continued From page 28 Staff must verify that uploaded documents have been successfully saved and associated with the correct resident profile. If the paper documents are provider or hospital visits or orders, they must be initialed and dated by nurse manager to show that we have seen them before scanning them in.	F 690			
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess trauma history and identify potential triggers for 1 of 1 resident (R25) who had a diagnosis of post-traumatic stress disorder (PTSD). Findings include: R25's admission Minimum Data Set (MDS) assessment dated 2/12/25, indicated moderately impaired cognition, feeling down, depressed or hopeless nearly every day, dependent on staff for personal hygiene, dressing, toileting, utilized a walker and wheelchair, diagnoses included psychotic disorder and post-traumatic stress disorder (PTSD), and antipsychotics were received on a routine basis.	F 699	F699 1. Resident R25 immediately received a trauma informed care assessment by social worker. Identified trauma triggers were documented in residents care plan. 2. Social Worker completed a trauma informed care assessment on all current residents to identify residents with diagnosis of PTSD, abuse history, or significant loss and care plans were updated to reflect triggers. 3. Education was given to the social worker on completing trauma informed care assessments upon admission and upon change of condition and documenting triggers in the care plan on 04/11/2025. 4. The Director of nursing, or designee		5/9/25

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F 699	Continued From page 29 R25's care plan dated 2/28/25, indicated medications daily for PTSD, psychosis, monitor/record occurrence of target behaviors: worried expression, verbalization of worries. monitor/record target behaviors: restlessness, wandering, pacing, exit seeking, unable to sit still to rest, administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, consult with pharmacy, medical doctor (MD) to consider dosage reduction when clinically appropriate at least quarterly, discuss with MD, family ongoing need for use of medication, review behaviors/interventions and alternate therapies attempted and their effectiveness. R25's annual Care Area Assessment (CAA) dated 2/12/25, triggered for Psychosocial Well-Being R25's mood interview indicates the presence of little interest or pleasure in doing things, when assessed, the resident was asked if he had little interest in doing anything, and he stated yes for 2-6 days, has been feeling down for 12-14 days due to everything happening to him, trouble falling asleep at night for 2-6 days and feeling tired for 2-6 days due to being unable to sleep at night, history of delusional disorders and unspecified psychosis. R25's Psychosocial Assessment dated 2/6/25,	F 699	will audit 20% of care plans for residents with a diagnosis of PTSD for care plan interventions weekly for four (4) weeks, then 20% of quarterly, and all new admissions and change of condition. 5. Results of the audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee for review and recommendations.		

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F 699	Continued From page 30 indicted sometimes traumatic events in a person's life can have an effect on how we heal from illnesses or react to certain situations now, would you like to discuss interventions that may help address these concerns, staff indicated that R25's response was no. On 3/31/25 at 1:58 p.m., R25 stated he had PTSD and some things that triggered his PTSD were flashbacks of his mom getting beat up, staff that were not patient, when staff made him wait a long time for help, voices and loud noises across the hall at night. On 3/31/25 at 6:55 p.m., nursing assistant (NA)-A stated R25 would become anxious and agitated when he talked about family and she would try to verbally diffuse the situation. On 3/31/25 at 7:01 p.m., registered nurse (RN)-B stated R25 had brain trauma and was not sure if R25 had a diagnosis of PTSD. On 3/31/25 at 7:04 p.m., R25 was laying in bed and stated he mainly stays in his room all day and will leave his room to go to therapy appointments, does not like to participate in group activities. R25 further stated I am in this "hole all day long", and "I wish people would come and talk and visit". R25 stated there is a list of activities to do, but I don't want to do those. R25 stated nobody comes to visit with me unless they are checking my catheter bag and stated wished people that worked here would come visit with me and not ignore me, because I feel like I am just staring and talking to a wall all day. On 4/1/25 at 9:18 a.m., RN-A, known as the nurse manager, stated R25's PTSD triggers were	F 699			

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F 699	Continued From page 31 expected on his care plan. RN-A stated R25's care plan included PTSD medications and side effects of medications, and confirmed R25's care plan lacked the PTSD triggers and interventions. RN-A stated she completed residents' assessments, and stated the director of nursing was responsible for updating the care plans. RN-A stated the social services role is new to the facility and not sure if social services had assessed R25 for PTSD and triggers. RN-A stated R25 went to appointments outside of the facility for mental health. RN-A stated the provider notes were not returned or shared with the facility. RN-A stated the notes would be helpful in the care of R25's PTSD and trauma informed care. On 4/1/25 at 9:47 a.m., health unit coordinator (HUC)-D stated she made R25's mental health appointments and gave R25 paperwork to bring to the appointments. HUC-A stated R25 did not return with paperwork from the appointments, and she had not called to get information regarding the appointments. HUC-D stated she was responsible to ensure resident information was returned to the facility and was expected to call if notes were not received. HUC-A stated the notes would be important for nursing to review and care for R25. On 4/1/25 at 9:59 a.m., SS-A stated she was responsible for the residents trauma assessments. SS-A stated prior to the end of February 2025, she was not aware if trauma assessments were completed. SS-A confirmed R25 did not have a trauma assessment completed upon admission and confirmed R25 had a PTSD diagnosis. SS-A stated she had not heard that R25 had any concerns with behavior or mood, and stated she would expect nursing to	F 699			

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F 699	Continued From page 32 make her aware of behavioral concerns, and if concerns then she would go talk with R25. SS-A stated the MDS coordinator was responsible for updating the care plans. On 4/1/25 at 11:26 a.m., during a follow up interview R25 was in his room lying in bed and stated he went to a therapist and a therapist came to talk to him once a week. R25 stated the social worker at the facility had not been in to talk to him. R25 stated it would be nice if someone who worked at the facility came in and talked to me about my feelings and had conversation with me about how I am doing. On 4/1/25 at 11:33 a.m., the activities director (AD)-A stated R25 does not want to do group activities, and does physical therapy, radio, and television. AD-A stated she occasionally goes and visits with R25, however could not remember when she last visited with him and had no documentation of one on one visits with R25. On 4/1/25 at 11:51 a.m., SS-A stated she visited and with R25 today and he expressed he was glad to talk to her. SS-A stated she completed the trauma checklist that had not been done and will use the trauma assessment for triggers and interventions on R25's care plan related to PTSD. On 4/1/25 at 12:40 p.m., the director of nursing (DON) stated a trauma assessment was expected to be completed upon admission. The DON stated she was unaware who was responsible for resident's trauma assessments. The DON stated she was not aware of R25 having a PTSD diagnosis, and stated the admission nurse was responsible for completing the care plan at the time of resident's admission,	F 699			

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OMB NO. 0938-0391

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F 699	Continued From page 33 and the DON updated care plans when needed. The DON stated social services was expected to round with residents and discuss any concerns. The DON stated trauma assessments were important to identify any potential triggers and guide resident care. Facility Trauma Informed policy dated 8/15/24, indicated: Purpose: To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. Develop an organizational culture that supports trauma-informed care. Include trauma-informed care as part of the QAPI plan, so that needs and problem areas are identified and addressed. As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Utilize trained and qualified staff members who have established a rapport with the resident to assess him or her for previous trauma. Interact with all residents and visitors in a manner that is welcoming and kind, without being intrusive. Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.).	F 699			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812			5/9/25

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F 812	Continued From page 34 The facility must - §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 monitor the concentration of sanitizer used in the 3-compartment sink to ensure proper sanitation for cleaning pots and pans. This had the potential to affect all 36 residents who were served food from the kitchen. Findings include: During observation and interview on 3/31/25 at 11:35 a.m., with dietary assistant (DA)-A, 3 sinks were being used to clean pots and pans. DA-A stated the pots and pans rarely if ever go thru the dishwashing machine. DA-A indicated they aren't currently testing the concentration of the sanitizer or checking temperatures of water used for washing. DA-A stated they change out the chemicals and is not sure if the contract company	F 812	F812 Dietary staff were observed not checking for sanitizer or temperature in the 3-sink washing system. All dietary staff were educated by 05/07/2025 regarding the use of the thermometer or PH strips and logging it into the sanitary logbook. Staff will be audited on compliance with the PH strips and logging it in the sanitary logbook by the Certified Dietary Director, or designee. Audits will be conducted 5 days a week for one month, 3 days a week for two months and quarterly. All audits will be brought to the quality		

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F 812	Continued From page 35 completes maintenance on the system or not. The chemical used for sanitizing dishes stated "Sunburst" on the container. During observation 3/31/25 at 6:21 p.m., C-B filled the 3 sink system to wash pots and pans. C-B stated they check the concentration of the sanitizer each time they wash the pots and pans and showed the "Quant Sticks" (all were sealed in individual packs) used but did not check the concentration of the sanitizer sink. During an observation and interview on 4/1/25 at 8:50 a.m., with dietary manager (DM)-A, 3 compartment sink was filled with water and sanitizer solution and dishes had just been washed and were sitting on the counter, still wet. DM-A stated they don't check temperatures of the water and use cold water for the sanitizing solution. DM-A stated staff should be checking the concentration of the sanitizing solution each time the sink is filled using the tape found above the sinks. DM-A checked the current concentration using sanitizer test strip tape and correct concentration (200 parts per million) was noted. DM-A stated they do not document these checks or temperatures and has no documentation to support this is being completed. During interview 4/2/25 at 7:26 a.m., cook (C)-B indicated they wash, rinse and sanitize the pots and pans in the three sink system. C-B stated contact time for leaving pots and pans in sanitizer is 1 minute. Facility Cleaning Dishes/Dish Machine policy dated 2010, included all flatware, serving dishes and cookware will be washed, rinsed and			F 812	assurance performance committee for review and recommendations.		

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F 812	Continued From page 36 sanitized after each use. Dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation. The policy did not include instructions for use for the 3 sink system for cleaning pots and pans but did include scrub pots and pans with a non-metallic scouring pad when necessary and rinse in the sink.	F 812			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct	F 851			5/9/25

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F 851	Continued From page 37 care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 1, 2024), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by			F 851	F851 1. The Executive Director was educated on the different payroll-based journals categories of direct care staff with administrative duties vs without. 2. The executive director or designee will distinguish the difference through		

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F 851	Continued From page 38 CMS.This deficient practice had the potential to affect all 36 residents residing in the facility. Findings include: The CMS payroll-based journal (PBJ) staffing data report indicated the following: Failed to have RN hours four or more days within the quarter: 10/12/24, 10/13/24, 10/26/24, 10/27/24, 11/9/24, 11/10/24, 11/23/24. Failed to have licensed nursing coverage 24 hours/day on the following dates: 10/4/24, 10/6/24, 10/13/24, 10/19/24, 10/26/24, 10/27/24, 11/2/24, 11/9/24, 11/10/24, 11/14/24, 11/15/24, 11/16/24, 11/17/24, 11/23/24, 11/24/24, 11/28/24, 11/29/24, 12/7/24, 12/8/24, 12/22/24 and 12/25/24. On 4/2/25 at 9:17 a.m., staffing specialist (SS)-E, stated she was responsible for the nurse staff schedules. SS-E stated the staff schedule ensured a licensed nurse was scheduled each shift (days, evenings, and nights) and 24 hours every day with a minimum of one registered nurse (RN) every 24 hours. SS-E indicated she has always been able to cover licensed nurses staffing for above required hours but they sometimes have to mandate staff stay to cover the shift until a replacement can be found. The DON has had to cover portions of the shift also due to last minute call ins. On 4/1/25 at 9:34 p.m., the administrator stated the facility uploads the payroll information from their automated payroll system to the PBJ staffing site except the contracted staff who are manually entered. The administrator indicated in June 2024, the facility had a change in their payroll	F 851	payroll and other verifiable and auditable data to submit accurate staffing hours. 3. Audits of Payroll Based Journaling submissions will be done, at minimum, monthly prior to submission end date. All discrepancies based on the audit with be edited prior to submission end date by the Executive Director, or designee, on a quarterly basis. 4. All audit results will be brought to the quality assurance performance improvement committee for review and recommendations.		

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F 851	Continued From page 39 system and have been having issues with the information uploading to the PBJ site correctly. The administrator indicated they had to manually enter all their hours for July, August and September as none of their data would transfer. The administrator indicated they are working with the new payroll system staff to correct this problem. The administrator added once information is uploaded to PJB you can not go in and manually correct it, which they would have done once they noted the issue with some data not uploading. Review of timecards for the above dates was completed. All dates reviewed for lack of RN coverage were verified to have an RN on duty at least 8 hours per day. Review of above dates for licensed staff 24 hours per day were verified to have licensed staff 24 hours per day on site. Schedules and time cards were verified and accurate.	F 851			
F 881 SS=E	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:	F 881			5/9/25

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F 881	Continued From page 40 Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any residents who had infections requiring antibiotic use. Finding include: On 4/1/25 at 2:16 p.m., during an interview with registered nurse (RN)-E also identified as infection preventionist, stated she tracked and documented infections and antibiotics use on a software program they started using in January 2025. Prior to this, the facility lost their electronic tracking system in June 2024 and she was not documenting on a tracking form, just "notes jotted down". Upon request, to review the previous year data, RN-E indicated she could attempt to get the notes, but it likely wouldn't make sense. Review of monthly antibiotic use data available for January 2025 to March 31, 2025 included: if acquired in house or present on admission, resident, unit/room number, infection onset date, type of infection, infection site, organism, medication, provider, isolation if used, outcome, and date infection resolved. Review of the data indicated 6 of 7 urinary tract infections (UTI) treated with antibiotics did not include culture results and analysis of antibiotic treatment. In addition to the 6 UTI infections, one infection was listed as bacterial cystitis and one infection with diagnosis as unknown. These 2 infections were also treated with antibiotics and did not include culture results and analysis of antibiotic treatment.			F 881	F881 Infection preventionist was educated immediately on the antibiotic stewardship policy and the need to ensure cultures for those residents identified with urinary tract infection. All residents identified in the Jan-March 2025 antibiotic review have had their records reviewed by the infection preventionist and the DON to assess where we could improve our procedures. All current residents identified with urinary tract infections orders were audited for culture and sensitivity tests. Audits will be conducted on residents with newly identified urinary tract infection for culture and sensitivity testing by the infection preventionist or designee. The Infection preventionist will contact the physician on call/medical director when culture and sensitivity orders are not already in place. Residents with infections that require the use of an antibiotic will have an evaluation when reasonably possible but before the antibiotic time out. Audits will be conducted by the Director of Nursing, or designee three (3) times per week for four (4) weeks. One (1) time per week for four (4) weeks and quarterly. All audit data will be brought to the quality performance improvement committee for		

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F 881	Continued From page 41 On 4/1/25 at 2:20 p.m., during interview, RN-E stated they have trouble getting cultures completed or results reported when patients go to the emergency department (ED). RN-E stated they are working with the local ED about other issues, but have not discussed the lack of cultures being completed on urine specimens, wounds and other infections being treated with antibiotics. RN-E stated she has not discussed this issue at quality assurance and improvement meetings at this time and stated she didn't have a lot of communication with the previous medical director. RN-E confirmed they do not know if the resident is placed on the correct antibiotic since no cultures are being completed. RN-E also confirmed they are not tracking overall infection rates or catheter associated urinary tract infections. RN-E confirmed antibiotic time outs are not occurring at this time. On 4/2/25 at 10:11 a.m., the director of nursing (DON) stated they are having issues with cultures on urines and other specimens being completed and confirmed it is rare when they actually get a culture completed. The DON confirmed continued issues with the local ED department but the facility has not addressed the lack of cultures at this time. The DON stated she would expect the antibiotic stewardship program to follow the policy and procedure which includes time outs for antibiotic use. Facility Antibiotic Stewardship policy dated 2/14/25, included: -The facility will maintain an antibiotic stewardship program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use ...This policy including	F 881	recommendations.		

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F 881	Continued From page 42 procedure section will be reviewed yearly to ensure that all objectives and conditions are being met to streamline procedures and algorithms, and to identify opportunities for enhancement. - Antibiotic "time out" will be used at 72 hours after antibiotic initiation or first dose in the facility. Each resident will be reassessed for consideration of antibiotic need, duration, selection and de-escalation potential. At this time, laboratory testing results, response to therapy, resident condition and facility needs will be considered. Completion of an antibiotic time-out must be recorded in the resident record. -Microbiologic specimen submission guidelines to be completed per Loeb algorithm. -First-line treatment recommendations: Prescriber's will base treatment recommendations on the following factors: Likely UTI cite, culture and antibiotic sensitivity data, and patient specific factors including age, sex, prior antibiotic use, allergy history, current drug therapy, renal function and presence of urinary catheter. -What will be measure and tracked: Antibiotic starts, compliance and use of antibiotic time-outs, antibiotic use and days of therapy, record-keeping protocol compliance, use of antibiotic time-outs and compliance with urine culture specimen submission guidelines. -Antibiotic use data will be complied monthly and reviewed by the consulting pharmacist. Consulting pharmacist and the infection preventionist interpret the monthly data, define any necessary action steps and compile information for the monthly tracking report.	F 881			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883			5/9/25

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F 883	Continued From page 43 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883			

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F 883	Continued From page 44 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R30, R34) reviewed for immunization status, had been provided education regarding the risks, benefits and potential side effects of the influenza and pneumococcal vaccines in accordance with facility policy and the Centers for Disease Control and Prevention (CDC) recommendations. Findings include: R30's facesheet printed 4/2/25, indicated an admission date of 2/20/25. R30's immunization record did not include any administration or refusal of influenza or pneumococcal vaccines. Review of documentation in electronic medical record (EMR) failed to indicate whether the resident/family had been provided education regarding risks, benefits and side effects about the influenza or pneumococcal vaccinations or if resident had received the vaccinations or refused.	F 883	F883 1. Resident R40 and R34 were met with individually to provider CDC-approved vaccine information sheets (VIS) for both influenza and pneumococcal vaccines. Documentation was updated to reflect education given. 2. A full audit of all current resident's immunizations status was completed by Infection preventionist and audited by Director of Nursing. Chart was reviewed for presence of education given for influenza and pneumococcal and a signed consent or declination present. 3. Education given to the Infection Preventionist on the immunization policy and procedure and the importance of educating all residents, regardless of vaccination status, on the risk and benefits of both on 04/11/2025. 4. The Director of Nursing, or designee, will audit all new admissions or change of		

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F 883	Continued From page 45 R30's admission Minimum Data Set (MDS) dated 2/26/25, included moderately impaired cognition but understands and is understood. During interview on 4/2/24, at 9:30 a.m., R30 stated he did not receive education on the risks or benefits of vaccinations on admission. R34's facesheet printed 4/2/25, indicated an admission date of 3/10/25. R34's immunization record did not include documentation of influenza or pneumococcal vaccines or that R34 was provided education on risks, benefits and side effects in the electronic medical record (EMR). No evidence was present the resident had received the vaccinations or refused. R34's admission MDS dated 3/10/25, included R34 had intact cognition and understands and is understood. During interview on 4/2/24 at 9:48 a.m., R34 stated she had not received education on the risks, side effects or benefits of vaccinations. On interview 4/1/25 at 3:17 p.m., registered nurse (RN)-E, also identified as infection preventionist, indicated R30 and R34 both declined the vaccines upon admission. RN-E confirmed the record lacked documentation of vaccine status for influenza and pneumococcal and she just realized this yesterday and has since corrected the issue. RN-E confirmed they do not give vaccine informational sheets or other hand outs or discuss the risks, benefits and side effects of medication if the resident refuses. On interview 4/2/25 at 10:11 a.m., the director of nursing (DON) stated she would expect all	F 883	condition weekly for four (4) weeks, then monthly for three (3) months to verify immunization education and documentation. 5. All audit information will be brought to the Quality Assurance and Performance Improvement Committee for review and recommendations.		

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OMB NO. 0938-0391

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F 883	Continued From page 46 residents to receive information on the risks and benefits of immunizations. Facility Influenza Vaccine policy dated 3/22, included the facility shall provide pertinent information and the significant risks and benefits of vaccines to staff and residents; for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy. Pro to the vaccination, the resident will be provided information and education regarding the benefits and potential side effects of the influenza vaccine Provision of such education shall be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Facility Pneumococcal Vaccine policy dated 3/22, included prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated are offered the vaccine series within 30 days of admission. If a resident refuses vaccination appropriate information is documents in the resident's medical record indicating the date of the refusal of the pneumococcal vaccine.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/03/2025. 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.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. 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	K 000			

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K 000	Continued From page 2 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. 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 57 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		5/20/25	

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K 211	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation that the corridor exit used for egress and receipt of deliveries exhibited a slab-to-slab height delta of greater than one-half inch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	K211 SS=D 1. The maintenance director/designee called cement company on 04/03/2025 to assess and determine the best remedy to fix the height delta of the cement slope to be in compliance. 2. The maintenance director/designee made rounds on all doors that were a means for egress from the door to be within the unit of less than 1/2 inch. 3. The maintenance department staff were educated regarding the egress on 5/2/2025. 4. The maintenance director/designee will monitor all door egresses for the height delta to be with in compliance by 5/5/2025. a. Any non-compliance concerns will be addressed immediately. b. Audits will be completed weekly x 3 weeks and quarterly for compliance. c. The Quality Committee will determine if continued auditing is necessary once 100% compliance is achieved for 2 full quarters.		
K 353 SS=F	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,	K 353			5/9/25

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K 353	Continued From page 4 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 REQUIREMENT 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. Findings include: 1. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that the sprinkler system testing was completed for Q4 - 2024. 2. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation in the Kitchen Freezer that the sprinkler head frangible bulb was absent of color and appeared to empty of fluid.			K 353	K353 SS=F 1. The sprinkler testing company was notified immediately of the non-compliance of documentation. There were also notified to come and inspect all sprinkler heads in the kitchen. 2. The sprinkler heads that needed replaced were completed on 4/8/2025 and the freezer sprinkler head needed a part. The sprinkler head will be replaced when the part is received. Cleaning of the heads were done on the same date. 3. The maintenance department staff were educated on 5/5/2025 on sprinkler head compliance. 4. The maintenance director/ designee will audit 20% of the sprinkler heads randomly 1 time per week for 4 weeks and monthly for 3 months and quarterly. a. All results will be brought to the Quality Committee for further review. The maintenance director will audit the documentation reports monthly for		

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K 353	Continued From page 5 3. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation in the Kitchen - Dishwashing Area that a sprinkler head exhibited signs of paint on the head. 4. On 04/03/2025 between 9:30 AM and 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. 5. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by a review of available documentation that the that 5-year maintenance and inspection was last completed on 02/04/2020. 6. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation and a review of available documentation that there was inconsistency between documentation for the 5-year (02/04/2020) and dating observed on the sprinkler system riser gage(s) (2021). An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	compliance with record keeping.		
K 712 SS=F	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	K 712		5/9/25	

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K 712	Continued From page 6 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 REQUIREMENT 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, 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted - 3rd quarter for 2nd Shift staff. 2. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by review of available documentation that there was lack of randomness in conducting fire drills (1st and 2nd shifts all conducted in 4th week of the month quarterly and patterned time-stamp(s) were present). An interview with Maintenance Director verified these deficient finding at the time of discovery.	K 712	K712 SS=F 1. The maintenance director/designee conducted a fire drill on the 2nd shift on 4/08/2025. 2. The maintenance director/designee was re-educated on record maintenance and for all fire drills and will note the randomness of at minimum 90 minutes in between drills. 3. The maintenance department staff were educated on 5/5/5025 regarding the process. 4. Audits of the fire drill records will be done monthly for completion and for time randomness by the maintenance director/ designee. All results will be brought to the Quality Committee for further review.		
K 761 SS=C	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.	K 761		5/9/25	

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K 761	Continued From page 7 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 REQUIREMENT 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, 5.2.15, 6.1, 6.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by a review of available documentation that door inspection documents presented conflicting information - as both "non-compliant" and "good" had been checked on door inspection form(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	K761 SS=C 1. The maintenance director/designee will use a new form for documentation of door testing for compliance. 2. The door compliance records will be maintained by the maintenance director or designee and will note compliance of the doors. 3. The maintenance department staff were educated on the new form and how to fill it out properly on 5/5/2025. 4. Audits of the documentation will be conducted monthly. All results will be brought to the Quality Committee for further review.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		5/9/25	

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K 914	Continued From page 8 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement proper documentation of electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 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 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by a review of available documentation that the facility failed to properly document the testing of electrical outlets in resident rooms in Wing 4, 5, and TCU.			K 914	K914 1. The maintenance director designee was provided education on the NFPA code for maintenance and testing of receptacles in resident rooms on 5/5/2025. 2. All resident room receptacles will be tested and documented from left to right. 3. Facility Maintenance Director/designee will maintain documentation and will use an updated form that will identify the physical condition, ground continuity, polarity, ground retention force and receptacle location. 4. The completed facility wide testing will be presented to the QA committee.		

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NAME OF PROVIDER OR SUPPLIER ST MARKS LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 400 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 914	Continued From page 9 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914			
K 918 SS=F	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.	K 918			5/9/25

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

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K 918	Continued From page 10 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT 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: 1. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation that the emergency generator remote annunciator panel was found located in closed Nurses Station - not accessible or visible for monitoring by facility staff. 2. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation that the emergency generator remote annunciator panel that was found located in closed Nurses Station had labeling identifying that it was servicing both Gen 1 and Gen 2 An interview with the Maintenance Director verified these deficient finding at the time of discovery.			K 918	K918 1. Wing 3 is opened with residents and staff where the annunciator panel is located on 5/2/2025. 2. Staff were educated on the location of the panel and the procedure when it is sounding by the staff development coordinator on 4/30/2025. 3. Audits will be conducted of the panel system quarterly by the maintenance director. 4. All audit data will be brought to the Quality Committee for review.		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			K 923			5/9/25

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K 923	Continued From page 11 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012			K 923	K923 1. Oxygen tanks were separated, with signage, into sections labeled Empty and		

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K 923	Continued From page 12 edition), Health Care Facilities Code, sections 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation in Wing 4 / 5 - Med Gas (O2) Storage Room there was mixed storage of empty / full cylinders. 2. On 04/03/2025 between 9:30 AM and 2:00 PM, it was revealed by observation in Wing 4 / 5 - Med Gas (O2) Storage Room there was combustible storage - cardboard box(s). An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	Full and all combustibles were removed on 4/29/2025 by the maintenance director/designee. 2. All nursing staff were educated on 4/30/2025 by the staff development coordinator. Maintenance staff were educated on 5/5/2025. 3. Audits of the Med/gas storage room will be conducted by the maintenance director/designee 3 x per week for 4 weeks and 1 x per month for 3 months. 4. All audit data will be brought to the Quality Committee for review.		