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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SGPI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00394

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245369**

2.STATE VENDOR OR MEDICAID NO.
(L2) **055842700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MARKS LIVING**
(L4) **400 - 15TH AVENUE SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/23/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 01/11/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/11/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2022

CMS Certification Number (CCN): 245369

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 15, 2021 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 11, 2022

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

RE: CCN: 245369
Cycle Start Date: September 30, 2021

Dear Administrator:

On November 23, 2021, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SGPI

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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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2 AOA 3 Other

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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 11/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/08/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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12/01/1986
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 26, 2021

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

RE: CCN: 245369
Cycle Start Date: September 30, 2021

Dear Administrator:

On September 30, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 30, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**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 9/27/21 through 9/30/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 9/27/21 through 9/30/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED:NO deficiencies were cited due to actions implemented by the facility prior to survey H5369126C (MN72142), H5369125C (MN60236) H5369124C (MN63336), The following complaints were found to be UNSUBSTANTIATED: H5369121C (MN75508) H5369122C (MN75379) H5369123C (MN57064) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 11/04/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		11/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583	Continued From page 2 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate window coverings that could be closed during personal cares for 1 of 1 residents (R25) reviewed for privacy concerns. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated 9/01/2021 indicated R25 had intake cognition, needed assist of 2 with bed mobility, transfers and toileting and an assist of 1 with dressing, locomotion on/off the unit and personal hygiene. During an observstion and interview on 9/28/2021 at 9:20 A.M., R25 stated half of the window blinds in his room were missing so when sitting on the commode anybody outside can see him. R25's bed was placed under the window which faced a courtyard that could be accessed by anyone on facility grounds. During a follow-up interview with R25 on 9/28/2021 at 2:09 P.M., R25 stated the window blinds have been missing since admission and staff are aware but nothing had been done. R25 stated it was very bothersome as anybody can look in and see R25 on the commode or while	F 583	F583 - SS D (Privacy- Window Coverings) 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Audit of all rooms including R25 with assessment of all window blinds in need of repair or replacement initiated. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? Room by room audit completed on 10/5/21 with 19 window blinds ordered for replacement based on audit findings. All 19 blinds were replaced by 11/2/21. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Weekly Audit x4 to be done by DON (or designee). On-going monthly audits to be completed by the Maintenance Department (or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583	Continued From page 3 receiving personal cares. During an interview on 9/29/2021 at 8:48 A.M., nursing assistant (NA)-C was asked how they provide privacy for R25 if half of the blinds are missing. NA-C stated they do the best they can and verified R25 was not receiving adequate privacy. During an interview on 9/29/2021 at 10:13 A.M., maintenance supervisor (MS) stated an unawareness of missing blinds in R25's room but would check with other staff as well as their automated system that staff use to initiate a repair. MS also verified the missing blinds were a privacy issue.	F 583	designee) beginning in December. Education for staff on use of TELS (computerized maintenance/work order reporting system) to report any issues or concerns with window coverings completed on 10/27/21 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Monthly Audits to be completed by the Maintenance Department or designee. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 11/15/21	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		10/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 757	Continued From page 4 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor medication side effects for 1 of 5 (R5) residents reviewed for unnecessary medications. Findings include: R5's face sheet, printed on 9/29/21, included diagnoses of dementia, constipation, and bullous pemphigoid (rare skin condition that causes blisters on skin). R5's annual Minimum Data Set (MDS) assessment dated 7/19/21, indicated R5 was cognitively intact, with adequate vision and hearing, speech was unclear as she spoke a combination of Spanish and English, was sometimes understood and could sometimes understand. R5 did not walk and required extensive assistance and/or was totally dependent upon staff for bed mobility, transfers, dressing, toileting and hygiene. R5 had a urinary catheter, and was frequently incontinent of stool. R5's care plan indicated on 2/4/21, occasional bowel incontinence, and a goal on 7/29/21, was for R5 to be continent during waking hours through the next review date. Interventions dated 2/4/21, included cleaning peri-area with each incontinence episode. Care plan interventions did	F 757	F757 SS D (Unnecessary Drugs) 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Medication/Senna-Lax for R5 was immediately placed on hold pending rounding providers instructions. Bowel status monitored daily for loose stool/constipation. On October 8, 2021 provider changed the order from scheduled to PRN. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? Review of all residents with scheduled Bowel regime, including R5, during regulatory visits with rounding PCP to determine if bowel medications should be scheduled or offered on a PRN basis. This will be on-going until all residents have had their regulatory visits completed within the upcoming quarter. 3.) What measures will be put into place,	

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F 757	Continued From page 5 not include monitoring frequency and consistency of stools. R5's physician orders included: -Senna lax [laxative] tablet, give 2 tablets by mouth two times a day for constipation. Hold if loose stools. The order and start date of the laxative was 11/7/20. -Foley catheter to be placed for MASD (moisture associated skin damage) wounds. Remove catheter when wounds have healed. Order date was 9/22/21. R5's medication administration record (TAR), indicated the laxative was given twice a day 9/1/21, through 9/28/21, and held on 9/29/21. R5's bowel elimination log in POC (point of care), the location within the electronic medical record (EMR) where nursing assistants documented, indicated R5 had 37 incontinent stools in 17 days, from 9/13/21, through 9/29/21. Sixteen of which were described as loose/diarrhea. During the same time period, no stools were described as constipated. During an interview on 9/29/21, at 10:18 a.m., licensed practical nurse (LPN)-B stated R5's whole bottom was excoriated due to moisture and her chronic skin condition, and as a result a urinary catheter was recently inserted. LPN-B realized today that R5 had been having frequent loose stools and therefore held the laxative. LPN-B stated it was not her practice to look at the number of stools documented in a residents EMR prior to giving a laxative, even though the order for R5 indicated the laxative was for constipation and to hold it if R5 had loose stools. LPN-B stated she relied on nursing assistants (NA's) to inform	F 757	or systemic changes made, to ensure that the deficient practice will not recur? All Nursing Staff instructed on Bowel Look up procedure at staff training on 10/27/21. Education also provided on 10/27/21 regarding Residents Bowel Movements and Interventions to be reported daily on 24 hour Report Sheet. As of 10/29/21- All scheduled bowel medications indicate within orders to hold if stool is loose. As of 10/29/21- Care Plans updated for residents with a history of loose stool and/or constipation. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Licensed Nurse Team Members to review the 24 hour shift reports daily which includes bowels. Nursing Leadership to be notified of any discrepancies regarding bowels. Any discrepancies will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 10/31/21	

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F 757	Continued From page 6	F 757		

her.

During an interview on 9/29/21, at 1:13 p.m., (NA)-D stated each time a resident had a bowel moment, she documented it in POC but did not usually tell a nurse about it, adding nurses looked at this documentation. NA-D stated she did not observe or take note of resident patterns of constipation or diarrhea.

During an interview on 9/30/21, at 8:25 a.m., registered nurse (RN)-A said when asked how a TMA (trained medication aide) or nurse would know to administer a laxative if a resident was constipated, or to hold a laxative if a resident had loose stools, RN-A stated "I don't think the TMA or nurse looks at POC before they give a laxative." "I don't think the communication between the NA's and the TMA and nurse always includes that." RN-A added that NA's document a bowel movement in POC, but are not always aware or think to tell someone if a resident had multiple stools. RN-A became aware yesterday that R5 had frequent stools and the laxative was held yesterday because of it. RN-A was not aware R5 had more than 30 incontinent diarrhea stools in a span of approximately two weeks. RN-A stated that should have been noticed before 9/29/21, adding that R5 had significant skin issues on her bottom and a urinary catheter was recently ordered to prevent urine from irritating the skin and stool would irritate it too.

During an interview on 9/30/21, at 11:09 a.m., the DON reviewed R5's electronic record regarding frequently of loose stools in the past two weeks and stated this situation had just been brought to her attention. The DON said communication between staff could be better about bowel

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F 757	Continued From page 7 movements, and stated R5's frequent loose stools should have been picked up by staff before now. The DON admitted R5 had skin issues related to MASD and a chronic skin disease, and frequent lose stools could exacerbate MASD. The DON stated she was planning to address this with staff and create a new process to improve this communication between nursing staff regarding resident bowel patterns. Facility policy titled Bowel Disorders - Clinical Protocol, with revised date of 9/2017, identified examples of gastrointestinal tract conditions, including residents with a history of diarrhea, alterations in bowel movements, and residents taking medications related to bowel motility. Nurses would assess and document/report quantitative and qualitative descriptions of diarrhea (how many episodes in what period of time, amount, consistency). Staff and physicians would identify risk factors related to bowel dysfunction such as diarrhea or dysmotility. The staff and physician would monitor the individual's response to interventions and overall progress; for example frequency and consistency of bowel movements.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		10/31/21

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F 761	Continued From page 8 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure inhalant medications and insulin pens were properly labeled with an open/use by date for 1 of 2 medication carts. Furthermore, the facility failed to properly store suppository medications according to manufacturer recommendations. In addition, the facility failed to ensure medication fridge temps were adequately monitored in 1 of 2 medication rooms. This had the capacity to effect all residents using insulin, inhalers or other multi-dose medications in the facility. Findings include: On 9/30/2021 at 11:37 A.M., Wing 4/5's medication cart was observed with trained medication aide (TMA)-A and director of nursing (DON) present and was found to have the following:	F 761	F761 SS E (Label/Storage of Medications) 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Immediate audit of medication carts completed and medications that were not dated and/or misappropriately stored meds were immediately disposed of, including Insulin Kwik pens for R20, Nasal spray and Insulin Kwik pens for R13, Insulin Kwik pens for R18, Insulin Kwik pens for R15, Insulin Kwik pens for R30, Spiriva Inhaler for R31, Azelastine nasal inhaler for R1, Fluticasone inhaler for R14, Albuterol Inhaler for R135, Albuterol inhaler for R3. In addition 1 bottle of Theratab M stock	

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F 761	Continued From page 9 - R20 had 1 of 2 open insulin kwik pens not properly labeled - R13 had 1 open nasal spray and 2 open insulin kwik pens not properly labeled - R18 had 2 open insulin kwikpens not properly labeled - R15 had 2 open insulin kwikpens not properly labeled - R30 had 2 open insulin kwikpens not properly labeled - R31 had 1 open Spiriva [used for COPD] inhaler not properly labeled - R1 had 1 open Azelastine [used to relieve nasal symptoms such as runny/itching/stuffy nose, sneezing, and post-nasal drip] inhaler and 1 open Spiriva inhaler not properly labeled - R14 had 1 open Fluticasone [used to prevent asthma attacks in adults and children] inhaler not properly labeled - R135 had 1 open Albuterol [used to treat or prevent bronchospasm in patients with asthma, bronchitis, emphysema, and other lung diseases] inhaler not properly labeled - R3 had 1 open Albuterol inhaler not properly labeled - 1 bottle of stock Theratab M [used to help growth and good health] expired on 5/21/2021 - 1 bottle of stock oyster shell calcium expired 6/2021 - The following residents had Perrigo (brand name) Bisacodyl suppositories[for constipation] stored in the bottom of the medication cart: R1, R20, R29, R30, R31. During review of manufacturer recommendations, Perrigo indicated suppositories should be stored in temperatures 20-25 degrees Celsius.	F 761	med and 1 bottle of Oyster Shell Calcium that expired were also destroyed. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? On September 30, 2021 audit of all current medications in cart completed for all residents. Medications that were expired, not properly labeled and/or stored incorrectly were also destroyed. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Signage placed on the outside and inside of the door of the refrigerators, individual labeled baskets placed in the refrigerator with date of open stickers and permanent markers. Education provided to Nurse/TMA staff at staff meeting on 10/27/21 regarding proper storage of medications, dating of opened medications and checks for medication expiration. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Weekly audits of all current medications in the med cart to be completed by Nurse	

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F 761	Continued From page 10 During an interview on 9/30/2021 at 02:00 P.M., TMA-A stated that when opening a new inhaler or insulin kwikpen staff are to write the date opened on the medication. During an interview on 9/30/2021 at 2:07 P.M., facility DON stated it is the expectation that staff label a multiuse medication such as an insulin pen, insulin vial or inhaler with the date it is opened and if no date has been written the medication will need to be thrown out as it is too difficult to track the exact date opened. DON stated the suppositories stored in the cart will need to be thrown away as well and verified the medication should have been stored in the fridge. In addition, the DON verified the fridge in Wing 4/5's med room should have been temperature checked at least daily and had not been in 8/2021 as well as 9/2021. Facility policy titled Administering Medications, last revised 4/2019, indicated when opening a multi-dose container, the date opened is recorded on the container. Facility policy titled Storage of Medications, last revised 11/2020, indicated the following: drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.	F 761	Managers or designee to ensure that medications are properly labeled, stored correctly and expiration has not occurred. Audits will occur weekly x4 then bi-weekly x2. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 10/31/21	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		10/31/21

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F 842	Continued From page 11 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 12 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to provide a consistent process for assessing, communicating and documenting a resident's condition when transferring to a hospital setting or during re-admission for 1 of 1 residents (R32) observed after re-hospitalization. Findings include: According to R32's electronic health record (EHR) Admission sheet, R32 diagnosis including Alzheimer's disease, hypertensive heart and	F 842	F842 SS D (Resident Records) 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Full set of assessments for resident, R32 completed on 10/18/21 . Monitoring for increased pain, aggression, incisional management, foley catheter cares and output put in place.	

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F 842	Continued From page 13 chronic kidney disease with heart failure and chronic kidney disease, type 2 diabetes mellitus, muscle weakness. According to a discharge minimum data assessment (MDS) assessment dated 8/10/21, R32 had an unplanned discharge with a return anticipated, transferring to an acute care hospital. According to a re-entry tracking MDS dated 8/13/21, R32 returned to the facility. On 8/15/21, an MDS discharge assessment showed that R32 had another unplanned discharge from the facility to an acute care hospital. On 8/19/21, R32's record showed an MDS entry tracking record dated 8/19/21. A review of the EHR progress notes lacked documentation as to what problems R32 was suffering prior a transfer to the hospital on 8/10/21, with no notes since 8/5/21. A review of the EHR assessment list did not reveal a pre-hospital assessment or a form in the EHR system called "E-Interact" which provides for documentation of the reason for transfer, including a nursing assessment. Further review of the EHR progress notes did not include a nursing note identifying the day that R32 returned to the facility from the hospital, the care he received at the hospital, or his condition upon readmission. No progress notes were found for 8/13/21 or 8/14/21. A Skin assessment dated 8/13/21 indicated R32 had "surgical incisions from laparoscopic surgeries" on the abdomen, but did not indicate how many incisions, size of incisions or anything to indicate their condition. Under the section that prompted for nurse analysis, "a. Information to be careplanned (include prevention measures in	F 842	2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? During the week of October 4th, a review of all recent readmissions, including R32 to ensure that residents have appropriate monitoring, orders and assessments in place. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Readmission checklist initiated for Nursing, including steps to take to ensure safe transfer back to facility, including assessments, medication changes, orders and monitoring, documentation and any follow ups with Primary Care Providers. Education provided on this readmission process on 10/27/21. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Director of Nursing or designee to audit each readmission to ensure adequate documentation in place. Audits will occur weekly x4 then bi-weekly x2. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be	

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F 842	Continued From page 14 place ..." the document indicated R32 had incisions, but did not provide any analysis or plan for care. According to a progress note in the EHR dated 8/15/2021, 1:25 p.m. the facility received a call from FM-A at 10:00 a.m. requesting they assess R32, but failed to say what had prompted FM-A to feel R32 needed assessment. Progress note indicated, "Residents [FM-A] called @1000 to see if we could check on [R32]. Assessment was done @1006 he was pale in color, lips blue, unable to respond to questions, lethargic, abdominal pain in surgical area, unable to sit up, shacking [sic], and stated he did not feel well. Vitals for AM were T-98.4, O2-95%, BP-113/54, P-72. Vitals on assessment T- 98.4, O2-92%, BP-87/49,P-77 R-12. I immediately called [FM-A] back @1008 per her request and received her permission to send him in to the ER to be evaluated emergently. Phone call to 911 @1010. [R32] left via ambulance @1031. On 8/19/21 EHR progress notes indicated R32 had returned from the hospital and been readmitted to the facility, and an admission assessment had been done. The 8/19/21 EHR "Nursing Assessment- V.4" document showed a review of all body systems, but failed to indicate R32 had recently been hospitalized or that he had undergone gall bladder surgery, or that he had returned to the hospital with an acute kidney injury. This document did not indicate how the plan of care should be altered after hospitalization. According to an interview 9/30/21, 1:38 p.m. a registered nurse (RN-B) stated she was unsure of	F 842	corrected? 10/31/21	

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F 842	Continued From page 15	F 842		

what the facility expectations were for documentation of condition, but said, as a nurse, if a resident had a change in condition it should be monitored with the appropriate assessment, including vital signs (VS) and should be reported as needed, and findings documented. Upon return from the hospital, RN-B stated it was standard practice to do a head-to-toe assessment and VS. RN-B was unsure of where the facility wanted that information documented, but thought it should go in either the progress notes, or under the assessment tab in the EHR. Following hospitalization for surgery, RN-B said it was standard nursing practice to monitor and document a resident's pain level, wound condition, and monitor for signs of infection.

According to an interview 9/30/21, 1:55 p.m. a licensed practical nurse (LPN-A) stated a change in condition should be carefully detailed in a resident's chart, and a nurse should notify a provider of any significant change in condition or request help from management to do so. LPN-A also stated an expectation upon re-admission for nurses to do an assessment of the resident's condition. LPN-A stated the nurse could document their assessment in the EHR Nursing Assessment-V.4 form, or they could do a "health status progress note." LPN-A said he had not been working when R32 was sent to the hospital in August, but understood that R32 had initially gone to the hospital due to gallbladder issues, and then again for uncontrolled pain; however, LPN-A confirmed the information in R32's EHR did not clearly show the sequence of events, what had been done for R32, the reason for sending R32 to the hospital on 8/10/21, nor did it show any nursing assessment of R32 post-operative status upon his return except to state he had

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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incisions. LPN-A stated he understood R32 had been seen by a physician in the facility prior to going to the hospital, but confirmed there were no progress notes stating this, nor were there any provider notes uploaded into the EHR. LPN-A stated the charting did not meet facility expectations, and "contained too many holes." LPN-A stated a lack of clear assessment and documentation of condition does not allow for continuity of care from nurse to nurse.

According to an interview 9/30/21, 2:28 p.m. the director of nursing (DON) stated an expectation for nurses to use good nursing judgement when a resident has a change in condition. DON stated the nurse should do an assessment of the individual, and get other nurses to assist if unsure of what to do. If the assessment should indicate a need for further evaluation, DON stated the provider should be notified and in emergent situations, the resident should be transferred to a hospital setting. DON stated nurses should send information to the hospital that includes information on the resident's condition and need for evaluation or hospitalization. DON identified the facilities EHR had a document called "E-interact" that would provide information to the hospital when printed, and would meet the need for facility documentation, but stated she was not familiar with the form. DON stated she was used to a different form, and would like the nurses to start using it, but confirmed she had not initiated this yet. DON stated an expectation for the hospital to provide the facility with documents that provide a summary of the resident's hospitalization, along with new orders; however, DON said, I expect communication from the hospital, but we don't always get it." DON also stated that when a resident returns from the

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F 842	Continued From page 17 hospital it should be treated like a new admission, with all new nursing assessments being completed and documented. DON stated the nurses should see if there is anything new that needs to be added, providing the following examples, "any pain, signs of infection, dietary changes, last bowel movement." DON stated an expectation for the nurse on duty to perform the admission assessment or to request help from the nurse manager or DON. DON reviewed R32's EHR for the transfer to hospital 8/10/21, return on 8/13/21 and stated she was unable to tell from the documentation what had been happening at that time. DON confirmed the record was unclear as to why R32 went back to the hospital. A request was made for facility policy related to hospitalizations, a document titled Transfer or Discharge, Preparing a Resident For with a copyright date of 2001 and revision date of December 2016 and no other date was provided. Policy indicated nursing services to be responsible to prepare a discharge summary and post-discharge plan, assist with transportation, complete a discharge not in the medical record and send records to the business office. The business office is listed as responsible for informing other departments and letting the resident and/or representative of any re-admission right, policies etc.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more	F 849		10/31/21

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F 849	Continued From page 18 Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status.	F 849		

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F 849	Continued From page 19 (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving	F 849		

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mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient

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F 849	Continued From page 21 as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: According to interview, observation and document review, facility failed to provide a system of coordination of care with a contracted hospice provider. This effected 1 of 1 residents (R1) who were observed for hospice care.	F 849	F849 SS D (Hospice) 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

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F 849	Continued From page 22 Findings include: According to the electronic health record (EHR) Admission Record/diagnosis list, R1 had been admitted to the facility on 9/20/2021 with diagnosis hypertensive heart and chronic kidney disease, chronic kidney disease. The EHR Admission Record also indicated an association with a hospice organization, but did not indicate he was currently receiving hospice or if he was, when the services had started. During an interview 9/28/21, 11:05 a.m. R1 said he had recently signed up for hospice services, but said he did not know when they would be coming to provide cares, he stated, "they just drop in." R1 did not know who his nurse manager was for hospice, nor had he received a calendar of when to expect visits. He said he was not always told when any hospice provider would be coming except for massage therapy who verbally informed him. During a review of records 9/28/21, 2:49 p.m. a three ring binder was found near the nurses' station with the name of the hospice provider on the cover. Inside the binder were paper dividers where information, notes, schedules and any other communication from the hospice provider could be filed, but only 2 handwritten communication sheets stating they had visited were found in the folder and nothing else. The binder did not contain the name of the hospice nurse manager or any other team member. The folder had a general number for the over-all hospice company, but no number was listed for the facility to reach the local office or the nurse manager for R1. A licensed practical nurse	F 849	On September 27, 2021 St. Croix Hospice contacted immediately with requests for POLST and Hospice Care Plan for R1 to be sent to the facility immediately. POLST and Care Plan obtained 9/27/21. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? On September 27, 2021 Immediate audit of all Hospice residents currently in the facility with checks to ensure POLST and Care Plan were in place at the facility. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? On September 27, 2021 Ecumen Hospice, St. Croix Hospice, Mayo Hospice and Heartland Hospice each were contacted. A signed agreement obtained from each of them to provide POLST on the day of Hospice Admission and Hospice Care Plan within 3 business days. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Nurse Managers to ensure that POLST are obtained on Day one of new admission to facility or	

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F 849	Continued From page 23 (LPN)-B confirmed there were no other documents with the binder, and stated the facility health unit coordinator (HUC) should scan any documents from hospice into their EHR. A review of the EHR failed to reveal a hospice schedule, plan of care, interdisciplinary team notes or any other information about the hospice services R1 was to receive. Facility provided a facility "resident care sheet." This document indicated the company from whom R1 would be receiving hospice services, but did not include any information about what hospice would be doing, or what the facility would be doing. According to an interview 9/28/21, 2:58 p.m. the facility HUC, stated that communication with R1's hospice provider had "been really awful" and "I'm not getting the orders I typically see and resident communication forms. I have not even seen a certificate of terminal illness." HUC also confirmed the facility had not received a signed POLST (provider orders for life-sustaining treatment) to support his physician order for a do not resuscitate order. During an interview specific to the POLST, 9/28/21, 3:31 p.m. LPN-A, unit manager, confirmed he understood that R1 had signed up for hospice services, and LPN-A said the facility had not had R1 complete a POLST since hospice would do that on the day he signed up for their services. LPN-A stated the facility had been having trouble getting information from the hospice provider. During an interview 9/28/21, 3:42 p.m. the facility director of nursing (DON) stated the hospice provider should have sent them a hospice plan of care, a POLST, and any other communications	F 849	admission to Hospice if resident currently resides at facility . Facility care plan to indicate Hospice admission and follow up call placed on the 3rd business day if the Hospice Care Plan is not received. POLST form is included in the new admissions packet and process. Audits will be completed by nurse managers or designee bi-weekly x4. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 10/31/21	

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about what would be or had been provided by hospice. DON stated they had been waiting on documents from the hospice provider

According to an interview 9/30/21, 9:55 a.m. DON stated the facility had just sent out a letter (dated 9/29/21) to hospice companies with whom they contract stating an expectation for the POLST to be provided to the facility on the day of admission, and for the care plan to be sent within 72 hours. DON stated an expectation for the hospice contact information to be accessible to staff, to know the hospice nurse manager and members of the interdisciplinary team. DON stated this information should be in a binder near the nurses' station. DON stated R1 had an initial care plan for the facility and this should provide information about hospice.

During an interview and observation, 9/30/21, 10:22 a.m. a nursing assistant (NA-A) stated she was aware R1 was to receive hospice services, but upon review of the hospice binder near the nurses' station was unable to find any information about the schedule, the plan of care or who R1's hospice nurse manager was. NA-A stated she did not know when hospice would be in the facility to provide cares to R1 and did not know what type of cares they would be providing.

A request was made for R1's initial care plan from the facility EHR. The document was dated as having been signed by LPN-A on 9/20/21 and by a certified dietary manager on 9/27/21. The care plan was not signed as having been reviewed or initiated by any facility registered nurse. The first focus area for R1 was listed as: resident has an ADL (activities of daily living) self-care deficit related to: acute respiratory failure, NSTEMI

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(heart diagnosis), followed by [hospice company]. Interventions were listed following this, but document failed to indicate what interventions hospice would provide Vs. what facility would provide. No other mention of hospice was made throughout the document until a focus on "pain" stating: "end of life comfort measures in place" but not defined as to what was hospice Vs. facility.

A request was made for a facility policy related to the coordination of care with hospice services. Facility provided a document titled Hospice Program with a copyright date of 2001 and a revision date of July 2017 and no other date. Policy indicated: 12. Our facility has designated (Name) [blank] (Title) [blank] to coordinate care provided to the resident by our facility staff and the hospice staff (Note: this individual is a member of the IDT [interdisciplinary team] with clinical and assessment skills who is operating with the State scope of Practice act.). He or she is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for resident receiving these services; K. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family; L. Ensuring that the LTC facility communicates with the hospice medial director, the resident' attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physician; M. Obtaining the following information from the hospice: (1) the most recent

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F 849	Continued From page 26 hospice plan of care specific to each resident; (2) hospice election form; (5) Physician certification and recertification of the terminal illness specific to each resident; (6) Names and contact information for hospice personnel involved in hospice care of each resident; (7) Instructions on how to access the hospice's 24 hour on-call system; (8) Hospice medication information specific to each resident; and (9) hospice physician and attending physician (if any) orders specific to each resident.	F 849		

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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 09/28/2021. 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 | 11/04/2021

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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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	**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 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 1 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 Type II (111) construction. In 1967 an addition was added to the East Wing and was determined to be Type II (111) construction. In 1981 an addition was added to the East Wing and was determined to be Type V (111) construction. In 1991 an addition was added to the North Wing	K 000		

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K 000	Continued From page 2 and was determined to be Type II (111) construction. In 2013 another addition was added to the facility and was determined to be of Type V (111) construction. Because the original building and 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 facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors 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 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 271	K271 SS=E - Discharge from Exits	11/3/21

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K 271	Continued From page 3 facility failed to maintain the exit discharge in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, 7.7. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-through of the facility that the Wing 5 Exit Door egress to grade had a vertical displacement greater than one-half inch presenting a fall and trip hazard. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 271	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sidewalk was painted to ensure it is visible to individuals utilizing that exit. Scheduled a date for American Waterworks to come in and assess the sidewalk to be mudjacked to increase the height of the sidewalk to level it out. American Waterworks is scheduled to come do their assessment on 11/16/21. After assessment is completed American Waterworks can start work 2 to 6 weeks after. They have put us on the rush list to get work done sooner if someone else cancels. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in Wing 4 and 5 have the potential to be affected by the deficient practice. All residents in the area during an emergency also have the potential to be affected. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Checking the sidewalk on the campus will be added to the Computerized maintenance	

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K 271	Continued From page 4	K 271	management and work order system prompting the maintenance personnel to check the sidewalk on a monthly basis. Also, it will be discussed at the next safety meeting to inform the committee members to keep an eye out for it and report any issues promptly to the Computerized maintenance management and work order system. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will audit the new systematic change to ensure compliance once a month for 3 months. Audits will be discussed and monitored by all team members during QAPI Meetings. 5. The date that each deficiency will be corrected? Sidewalk was painted on 11/3	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by:	K 281		11/2/21

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K 281	Continued From page 5 Based on observation and staff interview, the facility failed to provide illumination to the exit discharge in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.8, 7.8, and 7.9.1.1. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-through of the facility that outside of the Wing 3 exit door, no lighting fixtures were observed to provide illumination of the means of egress. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 281	K281 SS=E - Illumination of Means of Egress 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance director purchased a new light fixture to be mounted on the outside of the wing 3 exit door. Electrician installed light fixture on 11/2/21 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? Administrator and Environmental Service Director walked the grounds and made sure there were functioning external lights by the emergency exits of the SNF. No additional areas were out of compliance. All residents in Wing 3 have the potential to be affected by the deficient practice. Also, All residents in that area during an emergency evacuation also have the potential to be affected. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A task for checking all of the lights at the Emergency exit doors will be added to Computerized Maintenance Management and work order system. These checks will be	

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K 281	Continued From page 6	K 281	prompted on a monthly basis. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will audit the tasks once a month for 3 months. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 11/2/21	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		11/8/21

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K 324	Continued From page 7 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide clear access to the ansul type fire extinguishing equipment in accordance with the NFPA 101 (2021 edition), Life Safety Code, sections 19.3.2.5, 9.2.3, and 19.3.2.5.3(5)(b), NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.5.1. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during a walk-through of the facility Kitchen that the manual pull-station for the Ansul type fire suppression system was obstructed. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 324	K324 SS=D - Cooking Facilities 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The 36 inches around the manual pull-station for Ansul type fire suppression was cleared out. Tape was placed on the floor indicating not to store stuff in that space. Dining and maintenance staff will be educated to not stack anything within 36 inches of the pull station. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? No residents were affected by the deficient practice. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? The area was cleared out. Tape was placed on the floor marking the 36 inches around the manual pull station. Staff will be educated on 11/4/21.	

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K 324	Continued From page 8	K 324	4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will conduct an audit weekly for 4 weeks. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? 11/1/2021	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		11/8/21

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K 353	Continued From page 9 Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-through of the facility that in the Activity Room sprinkler heads exhibited signs of oxidation and were covered with a foreign substance 2. On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-through of the facility that items were placed closer than eighteen inches to the sprinkler head(s) in the following locations: Activity Office and North Storage Room These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 353	K353 SS=E - Sprinkler System - Maintenance and Testing 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Sprinkler head repairs will occur on the vendor's schedule. Staff will be educated not to store anything within 18 inches of a sprinkler head on 11/8/21. Tape was added to the north storage room to show staff not to stack above that tape on 11/4/21. The shelving unit in the activity office was removed on 11/4/21. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents participating in activities have the potential to be affected by the deficient practice. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Staff will be educated on not placing objects within 18 inches of sprinkler heads. A monthly task will be added on our Computerized maintenance management and work order system to check sprinkler heads are functional and no objects are obstructing the spray radius.	

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K 353	Continued From page 10	K 353	4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will audit once a month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? Training will be completed on 11/6/21 Obstructions were removed on 11/3/21 Sprinkler head repairs will occur on vendors schedule	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the accessibility of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 355	K355 SS=D - Portable Fire Extinguishers 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The obstruction to the fire extinguisher has been cleared on 10/29/21. Maintenance personnel will be educated on making sure fire extinguishers are free from obstructions on their fire	11/4/21

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K 355	Continued From page 11 On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-thru of the facility that in the basement corridor, a fire extinguisher was access obstructed. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 355	extinguisher checks. A repeating task has been added to our computerized maintenance management and work order system. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? Administrator and environmental service director walked the campus and made sure all other fire extinguishers were clear from obstruction. No residents were directly affected by the deficient practice as the location was far from resident area□s. The safety committee will also add this item to it□s agenda for further discussion. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Maintenance personnel will be educated to look for and clear obstructions to fire extinguishers on their fire extinguisher checks. This task description will be updated in our Computerized maintenance management and work order system 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will audit checks once a month for 3 months. Audits	

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K 355	Continued From page 12	K 355	will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? Education will be completed on 11/4/21 Obstruction was cleared on 10/29/21	
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	K 918		11/3/21

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

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K 918	Continued From page 13 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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 emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, and 5.6.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during the walk-through of the facility, and visual inspection of the three emergency power supply systems, that the age of the battery for Generator #1 could not be determined 2. On 09/28/2021 between 9:00 AM to 2:00 PM, it was revealed during documentation review that no weekly inspection records were available to review for any of the emergency power supply systems - Generators #1, #2, or #3 This deficient condition was verified by the Maintenance Director.	K 918	K918 SS=F - Electrical Systems - Essential Electric System 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Battery was replaced on generator #2 with date marked on 11/3/21. Environmental service director was educated on inspecting the generator, frequency of inspections, and documenting. Facility is also establishing a preventative maintenance contract to service the generators and ensure compliance. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents had the potential to be affected by the deficient practice. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Education will be provided to the maintenance director. Tasks will be added	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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

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K 918	Continued From page 14	K 918	in the Computerized maintenance management and work order system to check the generator at the required frequency. A preventative maintenance contract will ensure the system maintains compliance with NFPA standards. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator or designee will audit documentation of generator testing once a month for 3 months. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? Education will be completed on 11/3/21 Battery was replaced on 11/3/21	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		11/3/21

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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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K 920	Continued From page 15 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/28/2021 between 09:00 AM to 02:00 PM, it was revealed during the walk-through of the facility that high amperage appliances were connected to power-strips in the following locations: TCU - Nurse Managers Office, Director of Nursing Office, MDS Coordinating Office, and the Staffing Office. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 920	K920 SS=E - Electrical Equipment - Power Cords and Extension 1.) How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Maintenance personnel removed powerstrips that were being used for appliances and plugged the appliances directly into the outlets. Education will be provided to all staff that occupy an office that all appliances must be plugged directly into an outlet on 11/4/21. 2.) How will the facility identify other residents having the potential to be affected by the same deficient practice? Administrator and Environmental service director went through all the offices and anywhere a fridge, microwave, toaster, or coffee	

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K 920	Continued From page 16	K 920	maker was located and checked to see if any additional appliances were plugged into power-strips. 1 additional location was found in the TCU managers office with improper power-strip usage. 3.) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Education will be provided to all office staff on 11/4/21. Staff will need to request permission to have appliances in their office from maintenance personnel. Education on power strips will be provided at that time. 4.) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A task will be added on the Computerized maintenance management and work order system for maintenance personnel to check offices for improper use of power-strips. Administrator or designee will audit once a month for 3 months. Audits will be discussed and monitored by all team members during QAPI Meetings. 5.) The date that each deficiency will be corrected? Education will be provided on 11/3/21	

Electronically delivered
October 26, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: SGPI11

Dear Administrator:

The above facility was surveyed on September 27, 2021 through September 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/30/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/27/21 through 9/30/21, a licensing survey with complaints was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED:NO deficiencies were cited due to actions implemented by the facility prior to survey H5369126C (MN72142), H5369125C (MN60236) H5369124C (MN63336), The following complaints were found to be UNSUBSTANTIATED: H5369121C (MN75508) H5369122C (MN75379) H5369123C (MN57064) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 575	MN Rule 4658.0430 Subp. 1 Health Information Management Service Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations. This MN Requirement is not met as evidenced	2 575		10/31/21

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2 575	Continued From page 3 by: Based on interview and document review, facility failed to provide a consistent process for assessing, communicating and documenting a resident's condition when transferring to a hospital setting or during re-admission for 1 of 1 residents (R32) observed after re-hospitalization. Findings include: According to R32's electronic health record (EHR) Admission sheet, R32 diagnosis including Alzheimer's disease, hypertensive heart and chronic kidney disease with heart failure and chronic kidney disease, type 2 diabetes mellitus, muscle weakness. According to a discharge minimum data assessment (MDS) assessment dated 8/10/21, R32 had an unplanned discharge with a return anticipated, transferring to an acute care hospital. According to a re-entry tracking MDS dated 8/13/21, R32 returned to the facility. On 8/15/21, an MDS discharge assessment showed that R32 had another unplanned discharge from the facility to an acute care hospital. On 8/19/21, R32's record showed an MDS entry tracking record dated 8/19/21. A review of the EHR progress notes lacked documentation as to what problems R32 was suffering prior a transfer to the hospital on 8/10/21, with no notes since 8/5/21. A review of the EHR assessment list did not reveal a pre-hospital assessment or a form in the EHR system called "E-Interact" which provides for documentation of the reason for transfer, including a nursing assessment. Further review of the EHR progress notes did not include a nursing note identifying the day that R32 returned to the	2 575	Corrected	

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2 575	Continued From page 4	2 575		

facility from the hospital, the care he received at the hospital, or his condition upon readmission. No progress notes were found for 8/13/21 or 8/14/21.

A Skin assessment dated 8/13/21 indicated R32 had "surgical incisions from laparoscopic surgeries" on the abdomen, but did not indicate how many incisions, size of incisions or anything to indicate their condition. Under the section that prompted for nurse analysis, "a. Information to be careplanned (include prevention measures in place ..." the document indicated R32 had incisions, but did not provide any analysis or plan for care.

According to a progress note in the EHR dated 8/15/2021, 1:25 p.m. the facility received a call from FM-A at 10:00 a.m. requesting they assess R32, but failed to say what had prompted FM-A to feel R32 needed assessment. Progress note indicated, "Residents [FM-A] called @1000 to see if we could check on [R32]. Assessment was done @1006 he was pale in color, lips blue, unable to respond to questions, lethargic, abdominal pain in surgical area, unable to sit up, shacking [sic], and stated he did not feel well. Vitals for AM were T-98.4, O2-95%, BP-113/54, P-72. Vitals on assessment T- 98.4, O2-92%, BP-87/49,P-77 R-12. I immediately called [FM-A] back @1008 per her request and received her permission to send him in to the ER to be evaluated emergently. Phone call to 911 @1010. [R32] left via ambulance @1031.

On 8/19/21 EHR progress notes indicated R32 had returned from the hospital and been readmitted to the facility, and an admission assessment had been done.

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2 575	Continued From page 5 The 8/19/21 EHR "Nursing Assessment- V.4" document showed a review of all body systems, but failed to indicate R32 had recently been hospitalized or that he had undergone gall bladder surgery, or that he had returned to the hospital with an acute kidney injury. This document did not indicate how the plan of care should be altered after hospitalization. According to an interview 9/30/21, 1:38 p.m. a registered nurse (RN-B) stated she was unsure of what the facility expectations were for documentation of condition, but said, as a nurse, if a resident had a change in condition it should be monitored with the appropriate assessment, including vital signs (VS) and should be reported as needed, and findings documented. Upon return from the hospital, RN-B stated it was standard practice to do a head-to-toe assessment and VS. RN-B was unsure of where the facility wanted that information documented, but thought it should go in either the progress notes, or under the assessment tab in the EHR. Following hospitalization for surgery, RN-B said it was standard nursing practice to monitor and document a resident's pain level, wound condition, and monitor for signs of infection. According to an interview 9/30/21, 1:55 p.m. a licensed practical nurse (LPN-A) stated a change in condition should be carefully detailed in a resident's chart, and a nurse should notify a provider of any significant change in condition or request help from management to do so. LPN-A also stated an expectation upon re-admission for nurses to do an assessment of the resident's condition. LPN-A stated the nurse could document their assessment in the EHR Nursing Assessment-V.4 form, or they could do a "health status progress note." LPN-A said he had not	2 575		

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2 575	Continued From page 6	2 575		

been working when R32 was sent to the hospital in August, but understood that R32 had initially gone to the hospital due to gallbladder issues, and then again for uncontrolled pain; however, LPN-A confirmed the information in R32's EHR did not clearly show the sequence of events, what had been done for R32, the reason for sending R32 to the hospital on 8/10/21, nor did it show any nursing assessment of R32 post-operative status upon his return except to state he had incisions. LPN-A stated he understood R32 had been seen by a physician in the facility prior to going to the hospital, but confirmed there were no progress notes stating this, nor were there any provider notes uploaded into the EHR. LPN-A stated the charting did not meet facility expectations, and "contained too many holes." LPN-A stated a lack of clear assessment and documentation of condition does not allow for continuity of care from nurse to nurse.

According to an interview 9/30/21, 2:28 p.m. the director of nursing (DON) stated an expectation for nurses to use good nursing judgement when a resident has a change in condition. DON stated the nurse should do an assessment of the individual, and get other nurses to assist if unsure of what to do. If the assessment should indicate a need for further evaluation, DON stated the provider should be notified and in emergent situations, the resident should be transferred to a hospital setting. DON stated nurses should send information to the hospital that includes information on the resident's condition and need for evaluation or hospitalization. DON identified the facilities EHR had a document called "E-interact" that would provide information to the hospital when printed, and would meet the need for facility documentation, but stated she was not familiar with the form. DON stated she was used

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2 575	Continued From page 7	2 575		

to a different form, and would like the nurses to start using it, but confirmed she had not initiated this yet. DON stated an expectation for the hospital to provide the facility with documents that provide a summary of the resident's hospitalization, along with new orders; however, DON said, I expect communication from the hospital, but we don't always get it." DON also stated that when a resident returns from the hospital it should be treated like a new admission, with all new nursing assessments being completed and documented. DON stated the nurses should see if there is anything new that needs to be added, providing the following examples, "any pain, signs of infection, dietary changes, last bowel movement." DON stated an expectation for the nurse on duty to perform the admission assessment or to request help from the nurse manager or DON. DON reviewed R32's EHR for the transfer to hospital 8/10/21, return on 8/13/21 and stated she was unable to tell from the documentation what had been happening at that time. DON confirmed the record was unclear as to why R32 went back to the hospital.

A request was made for facility policy related to hospitalizations, a document titled Transfer or Discharge, Preparing a Resident For with a copyright date of 2001 and revision date of December 2016 and no other date was provided. Policy indicated nursing services to be responsible to prepare a discharge summary and post-discharge plan, assist with transportation, complete a discharge not in the medical record and send records to the business office. The business office is listed as responsible for informing other departments and letting the resident and/or representative of any re-admission right, policies etc.

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	00394	A. BUILDING: _____ B. WING _____	C 09/30/2021

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

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2 575	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could provide education to nursing staff on records needed for new admissions, and readmissions, including required assessments to inform the care of the resident, and actions to take should records not have been received. DON or designee could work with the person designated as in charge of records to ensure a procedure where the facility checks for the needed records upon admission and monitors or audits the records of new admits to ensure paperwork is being filed and is available to those who need the information in order to properly plan resident care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 575		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure inhalant medications and insulin pens were properly labeled with an open/use by date for 1 of 2 medication carts. Furthermore, the facility failed to properly store suppository medications according to manufacturer recommendations. In addition, the facility failed to ensure medication fridge temps were adequately monitored in 1 of 2	21620	Corrected	10/31/21

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21620	Continued From page 9	21620		

medication rooms. This had the capacity to effect all residents using insulin, inhalers or other multi-dose medications in the facility.

Findings include:

On 9/30/2021 at 11:37 A.M., Wing 4/5's medication cart was observed with trained medication aide (TMA)-A and director of nursing (DON) present and was found to have the following:

- R20 had 1 of 2 open insulin kwik pens not properly labeled
- R13 had 1 open nasal spray and 2 open insulin kwik pens not properly labeled
- R18 had 2 open insulin kwikpens not properly labeled
- R15 had 2 open insulin kwikpens not properly labeled
- R30 had 2 open insulin kwikpens not properly labeled
- R31 had 1 open Spiriva [used for COPD] inhaler not properly labeled
- R1 had 1 open Azelastine [used to relieve nasal symptoms such as runny/itching/stuffy nose, sneezing, and post-nasal drip] inhaler and 1 open Spiriva inhaler not properly labeled
- R14 had 1 open Fluticasone [used to prevent asthma attacks in adults and children] inhaler not properly labeled
- R135 had 1 open Albuterol [used to treat or prevent bronchospasm in patients with asthma, bronchitis, emphysema, and other lung diseases] inhaler not properly labeled
- R3 had 1 open Albuterol inhaler not properly labeled
- 1 bottle of stock Theratab M [used to help growth and good health] expired on 5/21/2021
- 1 bottle of stock oyster shell calcium expired

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21620	Continued From page 10 6/2021 - The following residents had Perrigo (brand name) Bisacodyl suppositories[for constipation] stored in the bottom of the medication cart: R1, R20, R29, R30, R31. During review of manufacturer recommendations, Perrigo indicated suppositories should be stored in temperatures 20-25 degrees Celsius. During an interview on 9/30/2021 at 02:00 P.M., TMA-A stated that when opening a new inhaler or insulin kwikpen staff are to write the date opened on the medication. During an interview on 9/30/2021 at 2:07 P.M., facility DON stated it is the expectation that staff label a multiuse medication such as an insulin pen, insulin vial or inhaler with the date it is opened and if no date has been written the medication will need to be thrown out as it is too difficult to track the exact date opened. DON stated the suppositories stored in the cart will need to be thrown away as well and verified the medication should have been stored in the fridge. In addition, the DON verified the fridge in Wing 4/5's med room should have been temperature checked at least daily and had not been in 8/2021 as well as 9/2021. Facility policy titled Administering Medications, last revised 4/2019, indicated when opening a multi-dose container, the date opened is recorded on the container. Facility policy titled Storage of Medications, last revised 11/2020, indicated the following: drugs and biologicals used in the facility are stored in locked compartments under proper temperature,	21620		

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21620	Continued From page 11 light and humidity controls. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper labeling and storage of medications. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27.	21942		11/2/21

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21942	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 38 families of residents who resided in the facility. During an interview on 9/28/21, at 10:14 a.m., activity director (AD)-A provided minutes from the last family council meeting dated 5/26/20. AD-A stated they had not had a meeting since then. Social worker (SW)-B had been responsible for facilitating the meetings and had ended employment in July 2021. Additionally, AD-A stated there was no family member council president. During a telephone interview on 9/29/21, at 3:00 p.m., family member (FM)-E stated she had attended past family council meetings, the last meeting was last year sometime. FM-E had not heard anything from the facility since that meeting. FM-E stated her family liked the meetings and hoped they would resume, adding they were very involved in their family members' care and living situation, and the meetings were important to them. During an interview on 9/30/21, at 8:58 a.m., the administrator stated they did not have a family council due to no social worker. During an interview on 9/30/21, at 1:13 p.m., AD-A provided dates of employment for social workers. The facility social worker (SW)-A's employment ended on 11/25/20. The next social worker SW-B was employed from 4/26/21 to 7/27/21. During the time with and without a social worker, the facility did not attempt to convene a	21942	Corrected.	

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21942	Continued From page 13 family council. Partial facility handbook, undated, with section titled: Resident and Family Councils, indicated family members were encouraged to voice their opinions and concerns without fear of reprisal. Family council was held on a regular basis at the discretion of family members. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure thorough attempts are made to develop a family council. The administrator or designee could develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		