DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2022

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

RE: CCN: 245369
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 26, 2022, we notified you a remedy was imposed. On September 7, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 2, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 10, 2022 be discontinued as of September 2, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 1, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 20, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 1, 2022

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

RE: CCN: 245369
Cycle Start Date: June 16, 2022

Dear Administrator:

On June 16, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 16, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 16, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
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 06/16/2022

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 6/14/22 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101	E 041		7/13/22

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

Electronically Signed | 07/10/2022

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

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E 041	Continued From page 1 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are	E 041		

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E 041	Continued From page 2 incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure they had implemented the emergency generator inspection and testing in accordance with the requirements. This had the potential to affect all 36 residents in the facility, all staff and visitors. Findings include:	E 041	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility generators are programmed to run under load every wednesday night between 8:00 pm and 9:00 pm. Facility will train EVS & maintenance staff to record the readings at least once monthly. Facility has	

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E 041	Continued From page 3 During a tour of the facility on 6/14/22 between 9:00 a.m and 1:00 p.m. and during documentation review, the environmental service director and administrator were unable to locate documentation to confirm that the required, one every 36 months-4 hour continuous, run of the emergency generators had been completed, In addition, no documentation was found for review to confirm that monthly inspections and run of the emergency generators had been completed. An interview with the Maintenance Director at that time verified the lack of documentation.	E 041	updated its contract with the generator vendor to include a 36 month 4 hour load bank test into their scheduled checks. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Maintenance staff will be trained on proper documentation of generator runs. A task for conducting and documenting generator tests was added to the Computerized Maintenance Management and work order system (TELS). Facility updated contract with Ziegler to include 4 hour checks every 36 months. Maintenance staff will be reeducated on the TELS system. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The EVS director will audit generator documentation once a month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected 7/13/22	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 4 On 6/13/22 through 6/16/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found NOT to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. AND The following complaints were found to be UNSUBSTANTIATED: H5369129C (MN79591) and H53692309C (MN83689). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 637		8/17/22

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F 637	Continued From page 5 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for a change in functional ability for ambulation, toileting, dressing, personal hygiene and transfers for 1 of 4 (R14) residents reviewed for activities of daily living (ADL). Findings include: R14's Face Sheet, included diagnosis of dysthymic disorder (long standing depression), heart failure, chronic kidney disease and type 2 diabetes. R14's quarterly Minimum Data Set (MDS) assessment dated 2/16/22, identified R14 was cognitively intact and required supervision (oversight, encouragement or cueing) with transfers, walking, dressing, toilet use and personal hygiene. The MDS also indicated R14 had one fall without injury and no weight loss. R14's quarterly MDS dated 5/16/22, identified R14 was cognitively intact, and required limited assist (resident was highly involved in activity and received physical help) of 1 with transfers, walking, dressing, toileting and personal hygiene. No falls were identified however a weight loss of 5% or greater was identified. R14's care plan last reviewed 2/8/22, included a self-care performance deficit related to impaired	F 637	F637 - SS = D How corrective action will be accomplished for those residents found to have been affected by the deficient practice? For resident R14: Comprehensive assessment completed- and care plan reviewed for accuracy How will the facility identify other residents having the potential to be affected by the same deficient practice? Weekly IDT initiated by team with any new change in condition to be addressed accordingly-Initiated 6/29/22 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility added portions to weekly IDT form identifying new concerns weekly at IDT including wt loss, functional decline, behavioral changes, pain, significant changes and falls.-Initiated 6/29/22 Process education scheduled 7/13/2022 Scheduled formal education on assessment documentation and accuracy scheduled for 8/17/2022 by MN State RAI Coordinator.	

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F 637	Continued From page 6 balance, difficulty walking and history of depression. The goal included the resident will maintain current level of function through review date. Interventions included the resident requires supervision to dress, requires assist of 1 to finish lower body and back for personal hygiene, is able to toilet self and is independent in room and on unit to transfer and walk with walker. A dietary progress notes dated 5/25/2022, at 2:12 p.m. included weight was down 7% over last thirty days and was attributable to decreased caloric intake. Staff were to encourage adequate intake and offer snacks between meals. During interview on 6/15/22, at 2:24 p.m., after review of February and May MDS registered nurse (RN-B) indicated she did not realize when completing the assessment R14 had a change in her abilities to perform ADLs and confirmed the care plan was not updated. RN-B indicated supervision is when staff should be close by and limited is more guided where they actually have a hold on the resident. When completing MDS, RN-B indicated she uses the most recent documentation done by the nursing assistants (NA)'s and licensed staff. RN-B indicated she hasn't seen R14 around as much since her fall . During interview on 6/16/22, at 9:26 a.m., the director of nursing (DON) reviewed February and May 2022 MDS and confirmed this is a change in condition and the care plan does not match most recent MDS. Upon review of recent fall, and weight loss, and change in MDS, the DON indicated a status change has occurred for R14 and this will be reviewed at next interdisciplinary team meeting.	F 637		

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F 637	Continued From page 7 A policy and procedure titled "Activities of Daily Living, supporting", last reviewed March 2018 included: -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents will be provided with care, treatment and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADLs are unavoidable -A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: -Independent - resident completed activity with no help or staff oversight at any time during the last 7 days. - Supervision - Oversight, encouragement or cueing provided three or more times during the last 7 days. -Limited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight being assistance 3 or more times during the last 7 days. - Interventions to improve or minimize a resident's function abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. -The resident's response to interventions will be monitored, evaluated and revised as appropriate.	F 637		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		7/13/22

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F 676	Continued From page 8 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 676	How corrective action will be	

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F 676	Continued From page 9 review, the facility failed to comprehensively assess and implement interventions to maintain and/or prevent decline in ambulation, toileting, dressing, personal hygiene and transfers for 1 of 4 resident (R14)reviewed for activities of daily living (ADLs). Findings include: R14's Face Sheet, included diagnosis of dysthymic disorder (long standing depression), heart failure, chronic kidney disease and type 2 diabetes. R14's quarterly Minimum Data Set (MDS) assessment dated 2/16/22, identified R14 was cognitively intact and required supervision (oversight, encouragement or cueing) with transfers, walking, dressing, toilet use and personal hygiene. The MDS also indicated R14 had one fall without injury and no weight loss. R14's quarterly MDS dated 5/16/22, identified R14 was cognitively intact, and required limited assist (resident was highly involved in activity and received physical help) of 1 with transfers, walking, dressing, toileting and personal hygiene. No falls were identified however a weight loss of 5% or greater was identified. R14's care plan last reviewed 2/8/22 included a self-care performance deficit related to impaired balance, difficulty walking and history of depression. The goal included the resident will maintain current level of function through review date. Interventions included the resident requires supervision to dress, requires assist of 1 to finish lower body and back for personal hygiene, is able to toilet herself and is independent in her room	F 676	accomplished for those residents found to have been affected by the deficient practice? For resident R14: Comprehensive assessment completed- and care plan reviewed. How will the facility identify other residents having the potential to be affected by the same deficient practice? Weekly IDT initiated by team with any new change in condition to be addressed accordingly-Initiated 6/29/22 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility added portions to weekly IDT form identifying new concerns weekly at IDT including wt loss, functional decline, behavioral changes, pain, significant changes and falls.-Initiated 6/29/22 Process education scheduled 7/13/2022 Scheduled formal education on assessment documentation and accuracy scheduled 8/17/2022 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Care plans, and assessments to be reviewed by DON or designee for accuracy at a rate of 10 weekly until all completed, then quarterly with ARD. The date that each deficiency will be	

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F 676	Continued From page 10 and on unit to transfer and walk with walker. The nursing assistant care sheet, undated, indicated R14 is independent in her room and on unit with front wheeled walker, ambulate to and from meals with supervision, and requires supervision to dress. The care area assessment notes dated on 8/30/21, for ADL's included: Decreased activity can result in complications such as pressure ulcers, contractures, falls, depression, and muscle wasting. Staff will assist resident as needed while encouraging her to participate as she is able. Staff will adjust care as needed with any changes that may occur and report changes to determine if referral is warranted. Will continue with care plan. Review of falls for R14 included: 2/8/22: R14 was found sitting on the floor next to her bed indicating she had gone to the bathroom, urinated down her leg and onto her pajamas, so had changed her bottoms and climbed back into bed, but was too close to the edge and rolled off. 4/5/22: R14 found sitting on the floor next to her bed. 6/4/22: R14 was transferring from bed to wheelchair and slid to the floor on her buttocks hitting her head on the bed. R14 has a small bump on the back of her head. A dietary progress notes dated 5/25/2022, at 2:12 p.m. included weight was down 7% over last thirty days and was attributable to decreased caloric intake. Staff were to encourage adequate intake and offer snacks between meals. During observation and interview on 6/13/22, at	F 676	corrected? 7/13/2022	

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F 676	Continued From page 11	F 676		

4:58 p.m., R14 was seated in her wheelchair in her room. A sign on the wall next to her bed read, call don't fall. R14 indicated she fell recently in her room and hit her head on the bed and still has a goose egg. R14 was unsure what happened. Denied any other falls while at the facility. R14 indicated she gets herself up to the bathroom and around her room with her walker and her wheelchair.

During observation on 6/14/22, at 8:15 a.m., R14 exited room in her wheelchair and propelled herself to the dining room.

During observation on 6/15/22, at 7:15 a.m., R14 was dressed and ambulated with walker to toilet and returned to room and sat in her wheelchair.

During observation and interview on 6/15/22, at 7:41 a.m., R14 was sitting in her wheelchair in her room and stated she can walk by herself with her walker and is up and around her room without any assitance. R14 included she goes to the bathroom without any staff in her room. R14 added she walks to dining room which is a long walk and her arms get sore as they think she puts too much weight on them. When asked if she felt her abilities to dress, toilet and walk were better or worse she responded "I don't really know." R14 then peddled herself in her wheelchair to the dining room.

During observation on 6/16/22, at 12:02 p.m., R14's family was present and wheeled resident in her wheelchair to the front entryway of the facility for lunch.

During observation on 6/16/22, at 1:03 p.m., family wheeled R14 back to her room and left.

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F 676	Continued From page 12 R14 wheeled self into the bathroom and toileted herself and self transferred back to her bed using hands on her bed to stand, moved wheelchair away and laid down. During interview on 6/15/22, at 8:29 a.m., nursing assistant (NA)-A indicated R14's physical abilities have not changed. She toilets herself, walks independently and can walk from her room out to the front door of the facility. NA-A indicated she is independent with personal hygiene, and only requires assistance to put on her stockings washes herself in the mornings. NA-A was not aware of any recent falls for R14. NA-A reviewed NA care sheet and indicated R14 is independent with her walker to and from meals, transfers, toilet use, and walking in her room. During interview on 06/15/22, at 2:15 p.m., licensed practical nurse (LPN) indicated she has not noticed any change in R14's condition and is up independently. R14 asks for help with her stockings and knows when she needs help but rarely uses her call light. During interview on 6/15/22 at 2:19 p.m., registered nurse (RN)-A indicated he generally works the night shift and R14 rarely uses her call light and generally doesn't require any assistance with toileting. During interview on 6/15/22, at 2:21 p.m., NA-B indicated R14 is independent with taking herself to the bathroom and with transferring. NA-B stated she has never seen R14 ambulate to the dining room and back and generally asks for help from staff to push her there in her wheelchair. NA-B indicated they try to encourage R14 to be as independent as possible.	F 676		

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F 676	Continued From page 13 During interview on 6/15/22, at 2:24 p.m., RN-B after review of February and May MDS indicated she did not realize she had a change in her abilities to perform ADLs and confirmed the care plan was not updated. RN-B indicated supervision is when staff should be close by and limited is more guided where they actually have a hold on the resident. When completing MDS RN-B indicated she uses the most recent documentation done by the NA's and licensed staff. RN-B indicated she hasn't seen R14 around as much since her fall and will bring this to meeting tomorrow for discussion and possible physical therapy (PT) evaluation since she hasn't been seen by therapy in a long time. Review of last physical therapy instructions for staff dated 8/27/21, indicated R14 was independent with transfers, bed mobility, ambulating in her room and transfers. Required front wheeled walker and stand by assist for ambulating to and from dining room. During interview on 6/16/22, at 9:26 a.m., the director of nursing (DON) indicated R14 has had one fall since she has been employed at the facility. The DON reviewed February and May 2022 MDS and confirmed this is a change in condition and the care plan does not match most recent MDS. Upon review of recent fall, weight loss, and change in MDS, the DON indicated R14 will be reviewed at next interdisciplinary team meeting. A policy and procedure titled "Activities of Daily Living, Supporting", last reviewed March 2018, included:	F 676		

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F 676	Continued From page 14 -Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents will be provided with care, treatment and services to ensure that their ADLs do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADLs are unavoidable -A residents ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: -Independent - resident completed activity with no help or staff oversight at any time during the last 7 days. -Supervision - Oversight, encouragement or cueing provided three or more times during the last 7 days. -Limited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight being assistance 3 or more times during the last 7 days. - Interventions to improve or minimize a resident's function abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. -The resident's response to interventions will be monitored, evaluated and revised as appropriate.	F 676		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		7/13/22

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F 697	Continued From page 15 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor or assess pain on an on-going basis, or offer non-pharmacological interventions for 1 of 1 residents (R27) reviewed for pain. Findings include: According to a facility conducted "pain interview" on 5/16/22, R27 was documented to have had pain at a level "six" (moderately strong) frequently over the previous five days. Indicators of pain were "vocal indicators" that were noted "daily". The document indicated R27 had Tylenol, 1000 mg every four hours for pain, and Voltaren 1% gel, 2 gms to be applied to his right knee every 12 hours. No further information regarding where R27's pain was located, how long it lasted, the quality of the pain or what was effective in relieving pain was found in the box for nursing comments. According to R27's Annual Minimum Data Set (MDS) assessment dated 5/17/22, R27 had frequent pain, scoring it at a level "six" and R27 was cognitively intact. According to a care area assessment (CAA) document dated 5/19/22, a decision was made to include pain in R27's care plan with the desired objective of "improvement." A review of R27's care plan did not find pain to have been added to that document. A review of R27's medication administration record (MAR) and treatment	F 697	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Initiation of nursing order to offer resident (R27) non pharmacological pain interventions every shift such as , Ice pack, warm pack, back rub, or repositioning if in pain on 7/1/22 How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility added portions to weekly IDT form identifying new concerns weekly at IDT including wt loss, functional decline, behavioral changes, pain, significant changes and falls.-Initiated 6/29/22 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Nursing education scheduled on non pharmacological pain management and modalities for pain relief meeting completed on 7/7/22. Process education scheduled 7/13/2022 Scheduled formal education on assessment documentation and accuracy scheduled for 8/17/2022 by MN State RAI Coordinator.	

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F 697	Continued From page 16 administration record (TAR) did not include a pain assessment had been added to that record. No listing for non-pharmacological pain relief intervention was found in the record. R27's diagnosis list included: a history of four fractured lumbar vertebrae and a current diagnosis of low back pain, cancer of liver/gall bladder and ducts, hyperuricemia (gout) causing inflammatory arthritis, and osteoarthritis of his right knee. According to an interview on 6/13/22, 4:34 p.m. R27 stated he does get some medications for his back pain. He further stated he was not fond of taking medications, would like to take less of them, but was not sure what they could do for his back pain. R27 stated he would like to get back-rubs, but this had not been offered. He did not recall anyone offering ice or warm packs when he complained of discomfort. During an interview on 6/16/22, 10:22 a.m. the director of nursing stated an expectation that a pain assessment should be done for all residents include the type of pain, severity, location, what helps to relieve it and what medications the resident is taking. DON stated pain assessments that indicate a problem should be discussed with the interdisciplinary care team to come up with interventions. Furthermore, the DON stated follow up pain assessments should be done to assess whether or not the planned interventions had been successful and updated as needed. DON stated individuals who do not care for pain medication should receive non-pharmacological interventions such as ice, heat, exercise or distraction, and perhaps therapy should become involved. DON also stated an expectation for pain	F 697	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Care plans, and assessments to be reviewed by DON or designee for accuracy at a rate of 10 weekly until all completed, then quarterly with ARD. The date that each deficiency will be corrected? 7/13/2022	

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F 697	Continued From page 17 to be included in a resident's care plan once they had been assessed to have a problem with discomfort. During an interview 6/16/22, 1:06 p.m. a registered nurse (RN)-C stated she was aware that R27 was having pain, but that R27 had chosen to cut back on his pain medications. RN-C said she thought R27 was "unrealistic about things." RN-C stated non-pharmacological interventions were available in the facility, but they did not add them to the MAR/TAR unless it was "requested by the resident." RN-C stated pain should be added to R27's care plan. A facility policy related to monitoring and providing pain relief was not provided	F 697		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to identify increasing symptoms of depression and provide appropriate mental health care for 1 of 1 residents (R27) reviewed for behavioral-emotional services.	F 740	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Antidepressant re- ordered at 125mg daily for depression on 6/17/22.	8/17/22

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F 740	Continued From page 18 Findings include: According to R27's Minimum Data Set (MDS) annual assessment dated 5/17/22, R27 had mood indicators of little interest or pleasure in doing things, feeling down, depressed or hopeless, and feeling tired and hopeless; all of these indicators occurred nearly every day. In addition, R27 was marked as every day having had frequent pain, scoring it at a level "six" (moderately strong). R27 was marked as being cognitively intact and with a diagnosis of depression. According to a patient health questionnaire for mood (PHQ9) entered into his admission MDS on 1/10/21, R27 had a score of "1" which indicated normal or no depression. R27 remained within the normal range of PHQ9 scores until a quarterly MDS on 11/19/21 indicated his score had risen to "6", an indication of mild depression. R27's PHQ9 score remained the same until his annual score, on 5/17/21 rose to a "9" indicating his mood had deteriorated and he was moving towards a moderate depression. According to R27's medication orders, on 9/22/21, the medical provider wrote an order for sertraline 50 mg tablets (anti-depressant), take two at bedtime (100 mg) for major depressive disorder. On 6/13/21, the sertraline dose was reduced to 75 mg at bedtime. According to R27's care plan, a focused problem area for the use of an antidepressant was last revised on 1/10/22 and a corresponding intervention indicated nurses should monitor the effectiveness of the medication every shift. An	F 740	Care plan revised and added depression symptom monitoring. How will the facility identify other residents having the potential to be affected by the same deficient practice? Weekly IDT initiated by team with any new change in condition to be addressed accordingly-Initiated 6/29/22 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility added portions to weekly IDT form identifying new concerns weekly at IDT including wt loss, functional decline, behavioral changes, pain, significant changes and falls.-Initiated 6/29/22 Process education scheduled 7/13/2022 Scheduled formal education on assessment documentation and accuracy scheduled 8/17/2022 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Care plans, and assessments to be reviewed by DON or designee for accuracy at a rate of 10 weekly until all completed, then quarterly with ARD The date that each deficiency will be corrected? 6/13/2022	

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F 740	Continued From page 19 additional focused problem area for a "mood problem-depression" was also last revised on 1/10/22. Associated interventions indicated R27's mood should be monitored, and behavioral health consults should be provided as needed. On 6/13/22, 4:24 p.m. R27 was interviewed and observed while in his bed, in his room. He kept the light off and stated he preferred the door to be shut. He expressed concerns about his care in relation to pain control, lack of therapy, disliking his room and staffing concerns. During the time he was interviewed, he received several text messages from "his girlfriend." He stated, "I'm always in trouble with her." R27 also said he was no longer getting up out of bed, but did not give a reason except vaguely mentioning the use of a Hoyer lift (mechanical lift used for person who are unable to bear weight). R27 did say he had just received news that he had received an "okay" to have a suprapubic catheter placed (surgically implanted urinary catheter) rather than the Foley catheter going into his urethra, and he was happy about the surgery. When interviewed on 6/16/22, 12:26 p.m. a registered nurse (RN)-C stated R27 had recently been having "issues with his girlfriend" and that this caused him to "go downhill" and to "get depressed." RN-C stated R27 had believed he was going to be discharging from the facility about six months prior, and planned to move in with his girlfriend, but this had not worked out, and RN-C stated, "that set him off." RN-C stated R27 would be eligible for mental health services with funds from the Veterans Administration (VA), but said, "he won't allow anyone to help him with the paperwork," and RN-C was unsure if R27 could get services in any other way. RN-C also	F 740		

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F 740	Continued From page 20	F 740		

stated R27 had "refused to work with therapy" and had been discharged from their services. She stated he then starting spending more time in bed because he didn't like to use the Hoyer lift and was just getting weaker. RN-C stated she thought R27 was unrealistic, and that he was looking for a "quick fix" so he could getter better and get back together with his girlfriend. RN-C stated she had noticed the medical provider had just reduced R27's anti-depressant, saying, "I wish she would have talked with me first."

When interviewed on 6/16/22, 10:22 a.m. the director of nursing (DON) stated that a resident exhibiting symptoms of a depressed mood should be assessed to identify causal factors and implement appropriate interventions. DON stated increased symptoms of depression should be reported to the medical provider and a medication review should occur. DON stated, self-isolation and taking to bed can be symptoms of increased depression and should be followed up on.

When interviewed on 6/16/22, 11:32 a.m. a nursing assistant (NA)-A stated R27 had become "pretty immobile" and not wanting to do things. NA-A stated R27 used to get up in his recliner and came to some activities, but no longer wanted to get out of bed. NA-A said, "I think he is depressed and he just doesn't really want to do things, yeah."

During an observation and interview on 6/16/22, 11:47 a.m. R27 was found in bed, the doors to the room closed, and the lights off. R27 was wearing a hospital gown, his appearance was of being sad, and his affect was flat. He had difficulty maintaining eye contact. He stated he was self-isolating and was depressed. He stated

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	245369	A. BUILDING _____ B. WING _____	C 06/16/2022

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
F 740	Continued From page 21 he had not been offered any VA paperwork to fill out in order to get mental health services. He also said he did not have anyone in the facility to talk with, but said when nursing assistant had told him she would take him out "sometime" because "she hates when she sees me depressed." R27 stated he was not aware he had been receiving an antidepressant and did not recall the medical provider discussing his mood or medications with him. When interviewed via phone on 6/16/22, 12:14 p.m. a certified nurse practitioner (CNP) stated she had not seen or talked with R27 since April, 2022, but had received a message from the pharmacist about reviewing R27's sertraline order for a gradual dose reduction (GDR). CNP stated she had not talked to R27 about reducing his medication, stating, "if a resident is having a problem with depression they [nurses] will usually write if there is a concern." CNP stated she was aware R27 had been struggling with his significant other and relationship and said, "he said it makes him sad." CNP stated refusal to participate in therapy, staying in bed and a rising PHQ9 score were symptoms of depression and should have been listed on the provider's "rounds sheet" for follow-up, but stated she had not received any communications about R27's depression. CNP stated an expectation for nurses to provide non-pharmacological interventions to the resident as well as notify the provider of mood concerns. CNP was not sure what services were available for R27 at the facility, but said she did not think they had a social worker to provide counseling. When interviewed on 6/16/22, 1:15 p.m. the facility administrator stated he was the social	F 740		

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F 740	Continued From page 22 service (SS) designee at the facility until they were able to rehire for that position. The administrator stated they had not had a social worker for about a year, but previously, the marketing director had been the SS designee before leaving in April. The administrator stated the nurse managers had taken over doing the SS assessments, and stated an expectation for the nurse managers to notify him of any changes requiring further assessment or intervention. The administrator stated he would hope a nurse manager would notify him if a resident's PHQ9 scores were rising so they could discuss a plan. The administrator also stated an expectation for the nurses to go to the DON, and to notify the provider of mental health changes. The administrator said they should discuss whether a referral to behavioral health was needed given any changes in mood status. The administrator also said he would be the one to assist residents in filling out any needed paper work, such as VA papers for funding of behavioral health services, but also said, he had not been informed of R27's mood decline, or the need for services. The administrator said, "VA has some good programs and there is someone there, in their offices, that can help as well." He did not recall R27's mood being discussed at any morning, interdisciplinary team meetings. The administrator stated an expectation for nurses to do a root cause analysis of R27's change in mood, to try to identify any underlying contributing factors and discuss this with him. The administrator stated nurses should attempt to motivate a person who is self-isolating and who refuses to get out of bed, by offering activities of interest. The administrator stated a nurse should be able to identify symptoms of depression per their licensure, and after talking with the resident should contact a medical	F 740		

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F 740	Continued From page 23 professional. A policy on behavioral healthcare was not provided.	F 740		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		7/13/22

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F 791	Continued From page 24 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide routine dental care for 1 of 1 residents (R15) who had concerns related to dental visits. Findings include: According to R15's Minimum Data Set (MDS) significant change assessment dated 5/9/22, R15 was cognitively intact and able to perform oral hygiene with set up help from staff. According to the MDS, R15 had his own natural teeth. During an observation and interview on 6/13/22, 2:39 p.m. R15 was observed to have his own, natural teeth, looking worn and aged. R15 stated, "I should have had my teeth taken care of a long time ago." R15 stated he could not recall when he had last been to the dentist, and was unsure if he had insurance and worried if he had a way to pay for dental care. R15 could not recall anyone at the facility asking him if he would like to see a dentist or discussing payment with him. According to R15's care plan dated 4/26/19, he had declined dental care at that time, but no further review or revision was marked in the	F 791	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Offered dental services and to arrange an appointment if the resident desires. Resident declined dental services on 7/8/2022. Also, previously declined dental services in nursing assessment dated 5/9/22. How will the facility identify other residents having the potential to be affected by the same deficient practice? Educate nursing staff on completing the Care Conference summary/Nursing which in the facility is to offer outside services such as vision, dental, podiatry etc. This will be completed with each new admission and with each annual care conference. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Utilization of the care conference summary assessment within Point Click Care per each admission and annual care conference schedule	

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F 791	Continued From page 25 subsequent three years. Documentation of care conference notes related to R15's were requested. Facility provided a care conference note dated 7/27/21, 1:45 p.m. The note indicated R15's family representative was not present and R15 did not attend, and the conference took place during IDT. No notation was found in the spot marked "last dental visit," and no referral to dental was marked. No further documentation was located upon review. During an interview on 6/15/22, 12:45 p.m. a registered nurse (RN)-C stated she was not aware of any recent discussion with R15 regarding dental care and said she thought they only asked about dental services upon admission. RN-C stated R15 had medical assistance (MA) so payment was not a concern. RN-C stated residents should have regular oral/dental assessments and care, but was unsure of whose responsibility it was in the facility to manage these things. During an interview on 6/16/22, 10:28 a.m. the director of nursing (DON) stated any resident with their own natural teeth should be offered a dental referral upon admission and at least annually. DON stated it was the responsibility of the nursing staff at the facility to assess residents' dental needs and make sure they have dental care as needed.	F 791	. Process education scheduled 7/13/2022 Scheduled formal education on assessment documentation and accuracy scheduled 8/17/2022 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Care plans, and assessments to be reviewed by DON or designee for accuracy at a rate of 10 weekly until all completed, then quarterly with ARD The date that each deficiency will be corrected? 7/13/2022	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/14/2022. 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		07/10/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST. MARKS LIVING is a one-story building, with a partial basement The building was constructed at (5) different times. The original building was constructed in 1963 and was determined to be of Type II (111) construction. In 1967, an addition was constructed to the East Wing that was determined to be of Type II (111) construction. In 1981 an addition was constructed to the East Wing and was determined to be of Type V (111)	K 000		

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K 000	Continued From page 2 construction. In 1991 an addition was constructed to the North Wing and was determined to be of Type II (111) construction. In 2003 another addition was constructed and was determined to be of Type V (111) construction. Because the original building and the (4) additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222		7/11/22

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K 222	Continued From page 3 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in	K 222		

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K 222	Continued From page 4 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors for operational integrity per NFPA 101 (2012 edition), Life Safety Code, section 19.2.2.2, 7.2.1, 7.2.1.4.5, 7.2.1.15, 7.2.1.15.7. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that Basement - Breakroom exit door needed in excess of 15 pounds-of-force to activate latch and in excess of 30 pounds-of-force to set in motion the door leaf An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 222	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility adjusted door, hardware, lubed hinges, and adjusted latch. Removed obstructions from the external part of the door (Leaves pile). How will the facility identify other residents having the potential to be affected by the same deficient practice? As both doors were in the basement no resident had the potential to be affected by the deficient practice. 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 egress doors will be added to the Computerized Maintenance Management and work order system (TELS). These checks will be prompted on a monthly basis. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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K 222	Continued From page 5	K 222	The EVS Director will audit egress doors once per month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings The date that each deficiency will be corrected? 7/11/22	
K 353 SS=D	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: 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 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 353	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility scheduled repair with vendor (Summit) to install escutcheon cover on 6/20/22.	6/20/22

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K 353	Continued From page 6 Systems, sections 5.1.3, 14.4. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation in the Kitchen walk-in freezer, that the sprinkler head was ice covered and the head assembly was also absent of an escutcheon cover. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility audited all sprinkler heads in freezers and coolers and identified zero additional sprinklers that needed to have an escutcheon cover installed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A task for checking sprinkler heads in the freezer and coolers at the Emergency exit doors will be added to the Computerized Maintenance Management and work order system (TELS). These checks will be prompted on a monthly basis. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The EVS director will audit TELS once per month for three months to ensure completion. Audits will be discussed and monitored by all team members during QAPI Meetings The date that each deficiency will be corrected? 6/20/22	
K 355 SS=C	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	K 355		7/22/22

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K 355	Continued From page 7 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain documentation associated to 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 7.2.4.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed during documentation review that the fire extinguisher maintenance log-sheet did not identify the individual(s) who completed the inspection of the individual extinguishers located through-out the facility An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	K355 SS=C How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Administrator and EVS director will train maintenance staff on proper documentation on log sheets by 7/22/22. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility audited all fire extinguisher logs and determined all residents had the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A task for documenting fire logs was added to the Computerized Maintenance Management and work order system (TELS). Maintenance staff will be trained on proper documentation. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Maintenance director will audit the next 3 rounds of fire extinguisher logs to ensure that proper documentation is maintained. Audits will be discussed and monitored by all team members during QAPI Meetings The date that each deficiency will be	

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K 355	Continued From page 8	K 355	corrected? 7/22/22	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4.1 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that upon testing of the smoke barrier door assembly, located by Wing 4/5 Nurses Station, it did not self-close and seal properly to resist passage of smoke An interview with the Maintenance Director and	K 374	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The door on wing 4/5 with the lip was closing faster than the other door which prevented the lip from being an effective smoke barrier. Facility adjusted the door hardware on the door in wing 4/5 so the door with the lip didn□t close before the other one. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility audited all fire doors to ensure proper closure and sealing. Maintenance staff have been	7/14/22

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K 374	Continued From page 9 Administrator verified this deficient finding at the time of discovery.	K 374	educated on what to look for on fire doors and to report any concerns to the EVS director. Facility determined that all residents had the potential to be affected by the deficient practice What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? A task for checking fire doors was added to the Computerized Maintenance Management and work order system (TELS). Maintenance staff have been trained on what to look for. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The EVS director will audit fire doors once a month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 7/14/22	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		7/22/22

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K 511	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility workspace to electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation in the Wing 3-N Mechanical Room that access to the electrical panel was fully obstructed by storage An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility removed obstructed material from within 3 feet of the electrical panels. Facility put new yellow tape down to signal staff not to store anything there. Nursing department, housekeeping, laundry, and maintenance staff will be trained on what the yellow tape represents by 7/22/22. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility will audit all electrical panels and make sure storage areas do not have supplies in front of electrical panels. All residents have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility will Inform Nursing department, housekeeping, laundry, and maintenance staff of the 36 inch regulation of material in front of electrical panels, and install yellow tape to floor 36 inches from the electrical panel. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

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K 511	Continued From page 11	K 511	recur. The EVS director will audit electrical panels' space to ensure nothing is stored within 36 inches. Audits will be done weekly for four weeks then monthly for two months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 7/22/22	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.5.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Vendor had tested fire dampers (3/14/22) within the regulated time frame but documentation had to be obtained from the vendor as the facility failed to store documentation and didn□t have it readily available during fire marshal documentation review. Facility reviewed its documentation storage practices and trained the EVS director on proper	7/8/22

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K 521	Continued From page 12 On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that no documentation was presented or available for review to identify the most recent smoke damper inspection and testing. Last confirmed date of testing was 03/29/2018 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	documentation storage. EVS educated on 7/8/22. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility did not identify any residents being affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Review documentation practices and implement scanning and uploading into google docs in case original documentation is damaged or misplaced. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Facility will audit scheduled regulatory documentation to ensure it□s properly stored once. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 3/14/2022 - was when the fire dampers were checked. Corrected 7/8/22	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712		7/29/22

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K 712	Continued From page 13 unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed during documentation review that the fire drill reports presented for review identified that the last documented fire drill was conducted in JAN. 2021. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The EVS director will be educated on the fire drill regulation, process and documentation by the Corporate EVS director. EVS director will also shadow the Ecumen Pathstone facility EVS director. 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. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? The EVS director will be trained on fire drills by 7/22. A task for conducting and documenting fire drills was added to the Computerized Maintenance Management and work order system (TELS). How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator will audit the fire drill	

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K 712	Continued From page 14	K 712	once per month for 3 months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 7/29/22	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 7.2.1.15.2, 7.2.1.15.4, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/14/2022 between 09:00 AM to 01:00 PM,	K 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? EVS and maintenance staff will be educated on NFPA 80 standard for fire doors and other opening protectives as well as proper documentation. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents	7/29/22

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K 761	Continued From page 15 during documentation review there was no evidence presented to confirm that annual inspection and testing of doors is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? EVS and maintenance staff will be educated on NFPA 80 standard for fire doors and other opening protectives as well as proper documentation. A task for conducting and documenting fire doors was added to the Computerized Maintenance Management and work order system (TELS). How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Administrator will audit documentation once after completing the annual checks. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 7/29/2022	
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line	K 914		7/22/22

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K 914	Continued From page 16 isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to record details associated to electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1, 6.3.4.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed during documentation review, that the documentation did not clearly identify the individual(s) and the date(s) on which the physical condition, ground continuity, polarity, and ground retention force of the individual outlets in resident rooms had been completed. 2. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that the documentation presented for review had two means to record and indicate pass / fail of each phase of outlet testing. Some	K 914	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? EVS director will educate maintenance staff on proper documentation and labeling of NFPA 99 receptacle testing log sheets. Facility will implement a uniformed Legend key for indicating (pass / Fail) 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. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility has an established receptacle program through the Computerized Maintenance Management and work order system (TELS). Maintenance staff will be re-trained on TELS and proper	

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K 914	Continued From page 17 forms used by the facility has a default legend key (P = Pass / F = Fail), while other forms implemented (X = Pass / checkmark = Fail). As not all forms included legends - clear and easy assessment of the documentation was difficult. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	documentation. Facility will ensure staff education on documentation upon hire. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. EVS director will Audit the next receptacle testing documentation to ensure it is properly completed. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 7/22/2022	
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	K 918		7/22/22

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K 918	Continued From page 18 accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation, that no documentation was presented for review to confirm that the required, once every 36 months - 4 hour continuous, run of the emergency generators is being completed. 2. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation, that no documentation was presented for review to confirm that monthly inspection and run of the emergency generators	K 918	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility generators are programmed to run under load every wednesday night between 8:00 pm and 9:00 pm. Facility will train EVS & maintenance staff to record the readings at least once monthly. Facility has updated its contract with the generator vendor to include a 36 month 4 hour load bank test into their scheduled checks. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Maintenance staff will be trained on	

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	245369	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/14/2022**

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

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K 918	Continued From page 19 is being completed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	proper documentation of generator runs. A task for conducting and documenting generator tests was added to the Computerized Maintenance Management and work order system (TELS). Facility updated contract with Ziegler to include 4 hour checks every 36 months. Maintenance staff will be reeducated on the TELS system. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The EVS director will audit generator documentation once a month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected 7/22/22	
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 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms	K 920		7/22/22

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K 920	Continued From page 20 (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 deploy extension cords and relocatable power-tap devices 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), and UL1363 This deficient condition could have an patterned impact on the residents within the facility. Findings include: 1. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that in the Staff Development Office that and extension cord was in use and providing power to a relocatable power-taps 2. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that he Rec. Director Office that daisy-chained relocateable power-taps were in use 3. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that in the Conference Room an high-amp appliance was	K 920	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 by 7/22/22. 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 maker was located and checked to see if any additional appliances were plugged into power-strips. Facility did not identify any additional misuse of powerstrips. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recure?	

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K 920	Continued From page 21 connected to a a relocatable power-tap An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Education will be provided to all office staff by 7/22/22. Staff will need to request permission to have appliances in their office from maintenance personnel. Education on relocatable power taps will be provided at that time. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The EVS director will audit offices once a month for three months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 07/22/22	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		6/21/22

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K 923	Continued From page 22 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store medical gas per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.2.3, 11.6.5 This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that in the Wing 4/5 - Med Gas storage room there was no clear identifiable separation as to storage locations for empty / full cylinders 2. On 06/14/2022 between 09:00 AM to 01:00 PM, it was revealed by observation that in the	K 923	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility contacted Northwest Respiratory Services to obtain additional holders for E cylinders on 06/14/22. Facility had Educated staff on 5/25/22 at the monthly meeting. Staff were again educated again on 6/21/22. Hospice staff had put the oxygen tanks in the room without securing them. Hospice staff have also been educated on securing 02 cylinders. Laminated signs were placed in the Oxygen room clearly stating empty / full cylinders. How will the facility identify other residents	

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K 923	Continued From page 23 Wing 4/5 - Med Gas storage room there were free-standing and unsecured O2 cylinders on the floor An interview with the Maintenance Director verified these deficient findings at the time of discovery	K 923	having the potential to be affected by the same deficient practice? All residents have the potential to be affected by deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility staff and hospice staff have been educated on securing cylinders. Facilities put up signs indicating where to store (empty / full) cylinders. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON or designee will audit the oxygen room twice per week for 4 weeks then once per month for 2 months. Audits will be discussed and monitored by all team members during QAPI Meetings. The date that each deficiency will be corrected? 06/21/22	