*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 9, 2024

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

RE: CCN: 245369
Cycle Start Date: December 21, 2023

Dear Administrator:

On December 21, 2023, 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 March 21, 2024 (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 June 21, 2024 (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:

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

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

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Electronically delivered
January 9, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: VP4T11

Dear Administrator:

The above facility was surveyed on December 18, 2023 through December 21, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

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 12/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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<br><br>On 12/18/23 to 12/21/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(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.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), | E 041 | | 1/16/24 |

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

Electronically Signed | 01/18/2024

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<br>§485.625(e)(1)<br>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 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.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>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.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>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.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>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 | E 041 | | |

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| E 041 | Continued From page 2<br>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.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. | E 041 | | |

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| E 041 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 ( 2010 edition ), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.3.5, 8.4.9, 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing is occurring for the two emergency generators that would provide emergency power to the facility.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.<br><br>Refer to LSC citation 918 | E 041 | How will corrective action be accomplished for those residents found to have been affected by the deficient practice?<br><br>St. Mark□s Living contracted Ziegler to conduct the 4-hour load test<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents had the potential to be affected<br><br>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?<br><br>The 36-month 4-hour load test will be added to our TELS system.<br><br>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.<br><br>Unable to audit due to interval length. Added to TELS that sends out automated reminders<br><br>The date that each deficiency will be corrected?<br><br>1/16/24 | |
| F 000 | INITIAL COMMENTS | F 000 | | |

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| F 000 | Continued From page 4<br>On 12/18/23 to 12/21/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO deficiencies cited:<br>H53697956C (MN90622),<br>H53697955C (MN89149),<br>H53697957C (MN94149).<br>H53697954C (MN94648)<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; | F 580 | | 1/11/24 |

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| F 580 | Continued From page 5<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations | F 580 | | |

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| F 580 | Continued From page 6<br>under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure resident (R19) and responsible party (FM-A) were notified of a room change for 1 of 1 resident (R19) reviewed for notification of change.<br><br>Findings include:<br><br>R19's significant Minimum Data Set (MDS) assessment dated 10/26/23 indicate R19 admitted to facility on 10/6/22 and had significant cognitive impairment. In addition, R19 dependent on staff for all tasks for daily living (oral and personal hygiene, toileting, shower/bathe, upper and lower body dressing) and all transfers. Also, R19 diagnoses included heart failure, diabetes, aphasia (comprehension and communication disorder resulting from damage or injury to the brain), hemiplegia (paralysis of one side of the body), depression, and respiratory failure.<br><br>During interview with R19's emergency contact and FM-A on 12/19/23 at 1:25 p.m., FM-A stated she was not informed of facilities decision to move R19 bedroom closer to the nursing station. FM-A stated, "No one told me anything".<br><br>During an interview on 12/20/23 at 11:18 a.m., health unit coordinator (HUC)-A stated R19, "has changed rooms" but was unable to recall when it occurred or if R19 and FM-A was notified of the decision.<br><br>During interview with trained medication assistant (TMA)-B on 12/20/23 at 11:27 a.m., TMA-B stated R19 was moved, "probably been about three | F 580 | How will corrective action be accomplished for those residents found to have been affected by the deficient practice?<br><br>Due to the inability to postdate documentation, we are unable to correct documentation for the Resident affected.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility reviewed all room moves in the last quarter and identified that 8 residents were moved. 8 out of the 8 resident room changes had the proper documentation in place.<br><br>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?<br><br>The facility implemented room change forms on 11/9/2023 after the incident was identified by the facility. Admin provided undocumented Education to DON & Nurse manager about the CMS rule about room changes. The facility has since moved 8 residents and 8 of 8 had forms signed, charted in PCC, and responsible parties notified.<br><br>On 1/11/24 the facility did a formal training for clinical leaders. Training included room transfer policy, the new form, and | |

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| | 245369 | A. BUILDING _____ B. WING _____ | C 12/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 580 | Continued From page 7<br>months". TMA-B stated she had asked management to move R19 to be closer to the nursing station for closer supervision due to his unwitnessed multiple falls. TMA-B stated, "there is a process for notifying" the family prior to changing rooms. TMA-B stated FM-A, "was pissed because we moved him" and, "as far as I know she was not told before his room change."<br><br>During interview with director of nursing (DON) on 12/20/23 at 11:27 p.m., the DON looked in R19's EMR and stated R19 was moved on 9/15/23, "after his last fall". DON stated expectation of staff to notify the resident and power of attorney (POA) [FM-A] before room change and to document it in the residents EMR. DON stated there was no evidence that R19's FM-A was informed of room change.<br><br>Facility policy titled Resident Rights revised February 2021 state "ii. Refuse a transfer from a distinct part within the institution". In addition, facility policy titled Change in a Resident's Condition or Status revised February 2021 state, "a nurse will notify the resident's representative when: there is a need to change the resident's room assignment". | F 580 | emphasized that leaders understood that the notice and form needed to be filled out 7 days prior to room transfer unless resident or responsible party consented to an earlier move date.<br><br>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.<br><br>DON or designee will audit the next 5 room changes to ensure that the new system has corrected the deficient practice. Audits will be discussed and monitored at QAPI Meetings.<br><br>The date that each deficiency will be corrected?<br><br>1/11/2024 | |
| F 625 SS=D | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- | F 625 | | 1/18/24 |

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| F 625 | Continued From page 8<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>During interview and record review the facility failed to ensure a written notice of bed hold was provided for 2 of 2 residents (R19, R33) reviewed for hospitalizations.<br><br>Findings include:<br><br>R19's significant Minimum Data Set (MDS) assessment dated 10/26/23 indicate R19 admitted to facility on 10/6/22 and had significant cognitive impairment. In addition, R19 dependent on staff for all tasks for daily living (oral and personal hygiene, toileting, shower/bathe, upper and lower body dressing) and all transfers. Also, R19 with diagnoses of heart failure, diabetes, aphasia (comprehension and communication disorder resulting from damage or injury to the | F 625 | How will corrective action be accomplished for those residents found to have been affected by the deficient practice?<br><br>Due to the inability to postdate documentation, we are unable to correct documentation for the Resident affected.<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>The facility audited 3 of 3 residents that were sent to the hospital in the last 30 days and determined 0 were out of compliance. | |

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| F 625 | Continued From page 9<br>brain), hemiplegia (paralysis of one side of the body), depression, and respiratory failure.<br><br>R19's progress notes indicate hospitalizations for 6/17/23, 7/14/23, 8/5/23, 8/27/23 and 9/18/23. R19's record indicated facility provided and documented bed holds for the 6/17/23 and 9/18/23 transfers. The EMR failed to provide information of a bed hold form being offered to R19 and patient representative (FM-A) for the following hospitalizations: 7/14/23, 8/5/23, and 8/27/23.<br><br>During interview with trained medication assistant (TMA)-B on 12/19/23 at 12:55 p.m., TMA-B stated expectation of facility to offer and provide the bed hold form to the resident or patient representative prior to or immediately after transfer.<br><br>During interview with director of nursing (DON) on 12/19/23 at 1:01 p.m., stated expectation of staff to provide bed hold forms to resident or patient representative "before they leave the facility" and a progress note in the EMR by staff to indicate whether the form was provided or not. DON looked in R19's EMR and stated she was unable to locate bed hold notices for R19's hospitalizations for 7/14/23, 8/5/23, and 8/27/23.<br><br>During interview with R19's FM-A on 12/19/23 at 1:25 p.m., FM-A stated, "I don't recall ever signing or hearing about a bed hold for him this summer."<br><br>R33<br>R33 record was reviewed for closed record - hospitalization. R33 is no longer in the facility. | F 625 | What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?<br><br>Educate clinical leaders, Admission team, nursing staff of the facility bed hold policy & form.<br><br>Added bed hold policy to admission packet<br><br>Nursing team educated on 1/11/2024<br><br>Business office admission team educated on 1/18/2024<br><br>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.<br><br>DON or designee will audit once a week for eight weeks. Audits will be discussed and monitored at QAPI Meetings<br><br>The date that each deficiency will be corrected?<br><br>- 1/18/2024 | |

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| F 625 | Continued From page 10<br>R33's Minimum Data Set (MDS) dated 9/5/23 indicated R33 was cognitively intact and was medically complex.<br><br>R33's care plan dated 9/7/23 indicated resident was admitted for acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues.)<br><br>R33's admission note dated 9/7/23 included R33 arrived via transport from family at 2 p.m. R33 had been hospitalized from 8/31/23-9/7/23 for Respiratory failure with hypoxia. R33 is alert and oriented times three. R33 denies having pain, POLST (Physician Orders for Life-Sustaining Treatment) signed, resident chooses to be FULL code. Oriented resident to TCU (Transitional Care Unit).<br><br>R33's progress noted dated 9/8/23 at 10:47 p.m., R33 was sent in to emergency room (ER) at 6:00 p.m., after multiple attempts for straight cath failed by registered nurse (RN). On-call physician gave an order for R33 to go to ER for immediate catheterization and placement of indwelling Foley until f/u by Urology. R33 was transported back to facility at 8:00 p.m., by sister. After visit summary indicated that R33 had an 18 fr indwelling catheter placed and RN stated that they drained 600 cc upon arrival in ER. R33 cath was draining well with 300 cc post catheter placement. R33 denied any pain, urine is clear and yellow. Nursing will continue to monitor as indicated.<br><br>R33's progress note dated 9/17/23 9:09 p.m., R33 requested to be transported to ER that morning at 8:00 a.m., after complaints of "chest pain and heart not feeling alright." RN completed quick verbal and physical assessment at bedside | F 625 | | |

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| F 625 | Continued From page 11<br>which yielded no apparent s/sx of myocardial infarction. RN reminded R33 that he had not taken his multiple morning medications which include cardiac regimen and no physical s/sx of concern noted at time of assessment.<br>R33 returned on 9/17/23 at 1:30 p.m., after visit summary had no changes to medication and plan of care, resident had labs scheduled for 9/18/23.<br><br>R33's progress noted dated 10/6/23 at 9:30 a.m., the facility was notified by phone from Nurse Practitioner that R33's morning labs show renal failure and WBC's elevated to the level of suspected sepsis. She requested resident be sent to hospital if he is agreeable. Nurse explained acute concerns to R33, who was then agreeable to being sent in. R33's sister was notified of transfer via phone and Ambulance transported resident to hospital at approximately 8:45 a.m.<br><br>During interview with director of nursing (DON) on 12/20/23 at 8:12 a.m., it was indicated that a bed hold was not provided. DON indicated they did not receive a referral for R33 to return to facility due to health status.<br><br>During interview with administrator on 12/20/23 at 11:12 a.m., it was indicated that residents and/or residents representatives are notified verbally of transfers. Administrator indicated that they do not do written communication for residents or resident representatives, however, they do fax or email communication to Ombudsman for transfers or discharges. | F 625 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2) | F 883 | | 1/11/24 |

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| F 883 | Continued From page 12<br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has | F 883 | | |

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| F 883 | Continued From page 13<br>already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure influenza vaccinations were offered to 1 of 5 residents (R4) reviewed for immunizations.<br><br>Findings include:<br><br>R4's admission Minimum Data Set (MDS) dated 10/31/23 identified R4 with admission to facility on 10/25/23, intact cognition and was dependent on staff for toileting hygiene and lower body dressing. In addition, R4 with indwelling catheter.<br><br>R4's medical diagnoses downloaded from his electronic medical record (EMR) on 12/20/23, indicate R4 with osteomyelitis to right ankle and foot (infection of the bone), diabetes, pressure ulcer to back, buttock, and hip, respiratory failure, heart failure, coronary heart disease, chronic clots to right lower leg, and urine retention.<br><br>R4's medical record lacked evidence R4 was educated about, offered, and received or declined | F 883 | How will corrective action be accomplished for those residents found to have been affected by the deficient practice?<br><br>The facility offered immunization to residents. Resident declined immunization and signed a declination form. Facility charted the declination and added it to residents' chart<br><br>How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>Infection Preventionist will audit all residents to ensure resident was either vaccinated or signed a declination form and that all charting is in place.<br><br>What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? | |

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| F 883 | Continued From page 14<br>the influenza vaccine.<br><br>During interview with facility's infection control preventionist (IP) on 12/20/23 at 10:04 a.m., the IP stated R4's influenza vaccination, "was missed. It should be charted in the EMR".<br><br>Facility policy titled Influenza Vaccine, revised March 2022 stated, "Prior to vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine." In addition, "Provision of such education shall be documented in the resident's /employee's medical record." | F 883 | The facility educated clinical leaders on the influenza vaccine policy.<br><br>Facility reeducated clinical leaders on the importance of collecting declinations and documenting when residents decline vaccination.<br><br>How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.<br><br>DON or designee will audit the next 5 admissions. Audits will be discussed and monitored at QAPI Meetings.<br><br>The date that each deficiency will be corrected?<br><br>1/11/24 | |

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| | 245369 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/19/2023** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/19/2023. 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>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 | 01/19/2024

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

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| K 000 | Continued From page 2<br>Wing and was determined to be of Type V ( 111 ) construction. In 1991 an addition was constructed to the North Wing and was determined to be of Type II ( 111 ) construction. In 2003 another addition was constructed and was determined to be of Type V ( 111 ) construction.<br><br>Because the original building and the ( 4 ) additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>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.<br><br>The facility has a capacity of 57 beds and had a census of 32 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 291<br>SS=F | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, a review of available documentation and staff interview, the facility | K 291 | A detailed description of the corrective action taken or planned to correct the | 1/19/24 |

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| | 245369 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/19/2023** |

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| **ST MARKS LIVING** | **400 - 15TH AVENUE SOUTHWEST**<br>**AUSTIN, MN 55912** |

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| K 291 | Continued From page 3<br>failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed during documentation review that no documentation was presented for review to confirm that 30-second monthly and 90-minute annual testing of emergency lighting is occurring.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 291 | deficiency.<br>- Facility added a reoccurring monthly task in TELS to do 30-second tests on emergency lighting<br>- Facility added a Reoccurring annual task in TELS to do 90-minute testing.<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- Facility added tasks to TELS<br>- Facility will educate maintenance team on inputting emergency light testing results into TELS<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- The administrator and EVS director get weekly reports from TELS on all tasks scheduled and if they have been completed in a timely manner.<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS Director<br>The actual or proposed date for completion of the remedy<br>- 1/19/2024 | |
| K 324<br>SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited | K 324 | | 1/24/24 |

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| K 324 | Continued From page 4<br>cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, documentation review, and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9), NFPA 99 (2012 edition), Health Care Factifies Code, section 15.5.2.3, and NFPA 96 ( 2011 edition ), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 11.4, 11.5, 11.6. This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings Include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the cooking device located in the Occupational Area did not | K 324 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- Electrician installed 120-minute timer to the power key that controls electricity to stove.<br>- Facility contracted with summit to complete inspections and annual cleaning of the range hood in the kitchen. Summit is scheduled to come on 1/24/2024 to complete cleaning Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- System enhancement, device was added to the stove as a backup to remove power in case the key was left in the wall and in the on position<br>- Summit was contracted to monitor | |

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| K 324 | Continued From page 5<br>have the proper lock-out, timeout, and disconnect hardware connected to the device.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation and documentation review that the range hood located in the main kitchen was grease and debris laden. The need for cleaning was noted in vendor documentation in prior 6-month inspection records.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 324 | and ensure compliance with range hoods<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- OT will notify maintenance if the timer device system malfunctions on Stove.<br>- Facility will receive reports from Summit on Range hoods located in kitchen<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- The Environmental Service director is responsible for corrective action and monitoring compliance.<br>The actual or proposed date for completion of the remedy<br>- 1/24/2024 | |
| K 355<br>SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, a review of available documentation and staff interview, the facility failed to properly inspect, and maintain 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 7.1.1, 7.1.2.1.6, 7.1.2.2, 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5. These deficient findings could have a | K 355 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- The fire extinguisher that wasn□t logged was checked and added to the log.<br>- Facility is contracting with (summit) to take over the fire extinguisher inspections. Summit will<br>keep a log of inspections and when | 1/19/24 |

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| K 355 | Continued From page 6<br>isolated impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation, that the fire extinguisher located in<br>the 4 / 5 Wing of the facility had been missed during NOV inspection.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed during documentation review that no vendor documentation was available for review.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 355 | fire extinguishers are rotated out of circulation.<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- Facility educated maintenance staff on the fire extinguisher map and log.<br>- Facility reviewed inspection checklist with maintenance staff<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- EVS director will audit the fire extinguishers once monthly for 3 months.<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS director<br>The actual or proposed date for completion of the remedy<br>- 1/19 | |
| K 374<br>SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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. | K 374 | | 12/19/23 |

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| K 374 | Continued From page 7<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the 4 / 5 Wing smoke compartment doors upon testing did not self-close and seal the opening.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the TCU smoke compartment doors upon testing exhibited a final door-to-door gap opening greater than 1/8 inch.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 374 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- 4/5 smoke compartment door - Hinge above door that was supposed to prevent one door closing before the other was defective. Since the doors were closing at staggering speeds it was closing in the proper order. Facility removed hinge.<br>- TCU smoke compartment door  Facility adjusted weather strip to remove the gap between the smoke compartment doors.<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- Facility removed hinge so it closes as needed<br>- Facility checked all fire doors to ensure they were closing correctly and had no visible gaps.<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- The facility will do visual inspection of doors once monthly.<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS director<br>The actual or proposed date for completion of the remedy<br>12/19 | |
| K 511 SS=F | Utilities - Gas and Electric | K 511 | | 1/19/24 |

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| K 511 | Continued From page 8<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>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.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F), 110.27(A)(1) This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that electrical panel 1L & 1R located in 4 / 5 Wing were found to be unsecured and readily accessible to unqualified individuals.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Chapel, the Electrical Room access door was found unsecured and would not properly latch to secure the room from unqualified individuals. | K 511 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- EVS director locked electrical panel<br>- Sellars lock & Key installed new lock on the chapel eclectic room.<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- Facility will educate maintenance team on ensuring that electrical panels and doors leading to<br>electrical rooms are secured at all times.<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- EVS director or designee will audit once weekly for 4 weeks<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS director | |

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| K 511 | Continued From page 9<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 511 | The actual or proposed date for completion of the remedy<br>- 1/19/2024 | |
| K 541 SS=F | Rubbish Chutes, Incinerators, and Laundry Chu<br>CFR(s): NFPA 101<br><br>Rubbish Chutes, Incinerators, and Laundry Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), | K 541 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- Facility replaced laundry chute door.<br>Address the measures that will be put in | 1/10/24 |

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| K 541 | Continued From page 10<br>section 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the 4 / 5 Wing of the structure that the laundry chute door did not close and seal the vertical shaft opening properly upon testing.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 541 | place to ensure the deficiency does not reoccur.<br>- Structural fix to building<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- Facility will do a visual inspection once monthly<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS Director<br>The actual or proposed date for completion of the remedy<br>- 1/10/2024 | |
| K 914 SS=D | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or | K 914 | | 1/19/24 |

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| K 914 | Continued From page 11<br>area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient condition could have a isolated impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that the documentation presented for review was incomplete as it did not capture information - not all forms were dated to identify when resident / client rooms were inspected / tested.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in resident room RM73 that a quad electrical box and electrical wire mold attached to the wall, was dislodged from the wall, directly adjacent to the resident sleeping bed.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 914 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- Quad electrical box dislodged: The incident happened while the fire marshal was in the building.<br>Staff notified the admin & EVS director of incident while touring the building with the fire<br>marshal. Upon inspection the facility called an electrician and had it fixed within 60 minutes of<br>being notified.<br>- Education was provided to the maintenance team on proper outlet testing documentation.<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- The facility will continue the current practice of fixing outlets as soon as it□s identified. Staff<br>are to notify Maintenance immediately upon identification of damage to outlets so it can be<br>addressed right away.<br>- Will educate clinical staff to be careful using equipment.<br>- Maintenance staff will be educated on proper outlet testing documentation<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- N/A<br>Identify who is responsible for the | |

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|---|---|---|---|---|
| K 914 | Continued From page 12 | K 914 | corrective actions and monitoring of compliance.<br>- EVS Director<br>The actual or proposed date for completion of the remedy<br>1/19/2024 | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing | K 918 | | 1/16/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245369 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **12/19/2023** |

| 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 |
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| K 918 | Continued From page 13<br>the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 ( 2010 edition ), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.3.5, 8.4.9, 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing is occurring for the two emergency generators that would provide emergency power to the facility.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 918 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- St. Mark□s Living contracted Ziegler to conduct the 4-hour load test for all generators<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- The 36-month 4-hour load test will be added to our TELS system.<br>- Contracted Ziegler to perform 4-hour load tests every 36-months<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- Facility added the Task into TELS. It will notify us prior to 36-month due date<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- EVS Director<br>The actual or proposed date for completion of the remedy<br>1/16/2024 | |
| K 923<br>SS=F | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and | K 923 | | 1/30/24 |

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| | 245369 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/19/2023** |

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

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| K 923 | Continued From page 14<br>ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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.<br>Less than or equal to 300 cubic feet<br>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.<br>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."<br>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.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections | K 923 | A detailed description of the corrective action taken or planned to correct the deficiency.<br>- Facility placed signs for staff to | |

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| | 245369 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **12/19/2023** |

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

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| K 923 | Continued From page 15<br>9.3.7, 9.3.7.5.3, 11.6.5. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the 4 / 5 Wing - Med Gas ( O2 ) Storage Room that there was mixed storage of empty / full cylinders.<br><br>2. On 12/19/2023 between 9:30 AM and 1:30 PM, it was revealed by observation and test in the 4 / 5 Wing - Med Gas ( O2 ) Storage Room, containing Liquid Oxygen, that the exhaust fan in the room was not operating.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 923 | indicate which side was full and which side was empty. Facility also placed tape to the storage containers to further indicate a division between full and empty containers<br>- Facility hired an electrician to replace the exhaust fan unit  completed 1/10/2024<br>Address the measures that will be put in place to ensure the deficiency does not reoccur.<br>- Facility will educate clinical staff on the importance of keeping the full & empty oxygen tanks<br>separate and on the new interventions in place to help indicate placement of oxygen tanks.<br>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br>- The RN trainer or designee will audit oxygen tank placement once a week for 4 weeks.<br>Identify who is responsible for the corrective actions and monitoring of compliance.<br>- RN Trainer<br>The actual or proposed date for completion of the remedy<br>- 1/30/23 | |

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|---|---|---|---|
| | 00394 | A. BUILDING: _____ B. WING _____ | C 12/21/2023 |

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 12/18/23 to 12/21/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, | 2 000 | | |

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| 2 000 | Continued From page 2<br>"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 21830 | MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 10. Participation in planning treatment; notification of family members.<br><br>(a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.<br>(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a | 21830 | | 1/11/24 |

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| 21830 | Continued From page 3<br>family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:<br>(1) examining the personal effects of the resident;<br>(2) examining the medical records of the resident in the possession of the facility;<br>(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and<br>(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br>(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county | 21830 | | |

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| 21830 | Continued From page 4<br><br>social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure resident (R19) and responsible party (FM-A) were notified of a room change for 1 of 1 resident (R19) reviewed for notification of change.<br><br>Findings include:<br><br>R19's significant Minimum Data Set (MDS) assessment dated 10/26/23 indicate R19 admitted to facility on 10/6/22 and had significant cognitive impairment. In addition, R19 dependent on staff for all tasks for daily living (oral and personal hygiene, toileting, shower/bathe, upper and lower body dressing) and all transfers. Also, R19 diagnoses included heart failure, diabetes, aphasia (comprehension and communication disorder resulting from damage or injury to the brain), hemiplegia (paralysis of one side of the body), depression, and respiratory failure. | 21830 | Corrected | |

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| 21830 | Continued From page 5<br><br>During interview with R19's emergency contact and FM-A on 12/19/23 at 1:25 p.m., FM-A stated she was not informed of facilities decision to move R19 bedroom closer to the nursing station. FM-A stated, "No one told me anything".<br><br>During an interview on 12/20/23 at 11:18 a.m., health unit coordinator (HUC)-A stated R19, "has changed rooms" but was unable to recall when it occurred or if R19 and FM-A was notified of the decision.<br><br>During interview with trained medication assistant (TMA)-B on 12/20/23 at 11:27 a.m., TMA-B stated R19 was moved, "probably been about three months". TMA-B stated she had asked management to move R19 to be closer to the nursing station for closer supervision due to his unwitnessed multiple falls. TMA-B stated, "there is a process for notifying" the family prior to changing rooms. TMA-B stated FM-A, "was pissed because we moved him" and, "as far as I know she was not told before his room change."<br><br>During interview with director of nursing (DON) on 12/20/23 at 11:27 p.m., the DON looked in R19's EMR and stated R19 was moved on 9/15/23, "after his last fall". DON stated expectation of staff to notify the resident and power of attorney (POA) [FM-A] before room change and to document it in the residents EMR. DON stated there was no evidence that R19's FM-A was informed of room change.<br><br>Facility policy titled Resident Rights revised February 2021 state "ii. Refuse a transfer from a distinct part within the institution". In addition, facility policy titled Change in a Resident's Condition or Status revised February 2021 state, | 21830 | | |

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| 21830 | Continued From page 6<br>"a nurse will notify the resident's representative when: there is a need to change the resident's room assignment".<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the physician. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21830 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
February 7, 2024

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

RE: CCN: 245369
Cycle Start Date: December 21, 2023

Dear Administrator:

On January 31, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, 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

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

February 7, 2024

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

Re: Reinspection Results
Event ID:  VP4T12

Dear Administrator:

On January 25, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 21, 2023.  At this time these correction orders were found corrected.

Please feel free to call me with any 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