Electronically delivered
December 10, 2019

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

RE: CCN 245369
Cycle Start Date: October 7, 2019

Dear Administrator:

On October 28, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 26, 2019.

This Department also recommended that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

On November 13, 2019, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On November 13, 2019, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

REMEDIES

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 26, 2019, will remain in effect.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Due to the results of the November 13, 2019 survey, St Marks Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 13, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Marks Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 13, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team

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
Phone: (507) 206-2731
Fax: (507) 206-2711

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 their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 7, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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 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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 11/13/2019

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 000	INITIAL COMMENTS On 11/8-11/13/19 abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to ensure resident's were free from abuse, failed to investigate and failed to protect residents from abuse following an allegation of physical abuse by staff. The IJ began on 10/24/19, the administrator and director of nursing were of the IJ on 11/12/19, and the immediacy was removed on 11/13/19. In addition, an extended survey was completed on 11/13/19, related to the substandard quality of care findings. The following complaints were investigated: H5369083C was found substantiated at F580 and 600 H5369084C Not substantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2019

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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F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's were free from abuse, failed to investigate and failed to protect residents from abuse following an allegation of physical abuse by staff. This resulted in an immediate jeopardy (IJ), with risk of serious harm, for 1 of 3 (R1) residents reviewed for allegations of abuse. The IJ began on 10/24/19, when R1 was noted to have bruising in her perineum and alleged a staff person had hurt her. The IJ was identified on 11/12/19, and the administrator and the director of nursing were informed of the IJ on 11/12/19, at 1:46 p.m. The IJ was removed on 11/13/19, at 10:57 a.m. but non compliance remained at the lower scope and severity level of G, isolated with actual harm. Findings include:	F 600	1. Corrective Action: Executive Director, DON and department heads will review VA Reporting Documentation and VA Process Best Practices and sign off acknowledgement and understanding. Training included instruction on how to appropriately conduct a thorough investigation, as well included best practices regarding how to implement interventions to prevent reoccurrence. Executive Director and Director of Nursing will review documentation and process listed above with Quality Improvement Nurse with Ecumen on 11/12/2019. All nursing staff who were assigned to care for resident R1 10/23, 10/24, and	12/12/19

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F 600	Continued From page 2 A Facility Reported Incident submitted to the State Agency on 10/24/19, at 7:57 p.m. indicated an allegation of physical abuse occurred on 10/24/19, at 6:30 p.m. The report included, "RN [nurse name] called DON (director of nursing) to inform that when she went to administer resident's (R1) vaginal cream, resident had blood in her pad. Nurse [nurse name] requested assistance and was joined by TMA (trained medication assistant). Both employees reported witnessing scratches on resident's inner thighs and several bruises. Employees asked resident how this occurred and resident reported CNA (certified nursing assistant (NA-1)) 'with the sparkly hair', was rough during cares when she was getting ready for bed. CNA responsible during cares matching physical description was suspended immediately pending investigation. Nurse and TMA cleansed resident, measured wounds, applied cream to wounds which resident reported felt better, and administered Tylenol for pain relief. Resident reported she felt safe and was ready for bed." The report further indicated the resident's family member was notified, and the physician would be notified in the morning. The summary indicated the facility would continue to monitor R1's mood/behavior, complete skin checks, treatments, and pain level during investigation. Further, the report indicated the investigation would include interviews with other residents, review of medication and treatment administration records, wound assessments, nursing assistant care sheets, and care plan. R1's quarterly Minimum Data Set (MDS) assessment dated 9/20/19, indicated R1 did not have cognitive impairment, did not have signs and symptoms of delirium, and did not exhibit any	F 600	10/25 date to be interviewed to determine if signs/symptoms of abuse were present as it relates to resident R1. CNA involved in incident was removed from the facility, with work contracting ended on 10/29/19. 2. Corrective Action as it applies to other residents: Review of Abuse policy and training Reviewed at mandatory CNA meeting 11/12/2019. Direct nursing care staff who did not attend the meeting but are currently on the site will have Abuse policy and training completed 11/12/2019 by DON or designee. Copies of Abuse policy and training will be placed at each nurse's stations and CNA desks for direct care nursing staff to review prior to working the floor. No direct care nursing staff will be allowed to work with residents prior to completing their education after 11/12/2019. Department heads will be present at each shift change starting 11/12/2019 until 11/15/2019 to make sure all staff have reviewed Abuse policy and expectations prior to providing direct care to residents. Direct Care Nursing staff who have not completed the training will be removed from the schedule after 11/15/2019 until they have completed the designated training with DON or designee.	

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F 600	Continued From page 3 behaviors. The MDS indicated R1 required extensive assistance from one staff member for all activities of daily living with the exception of eating. The MDS also indicated R1 did not have impaired skin integrity. R1's facility Admission Record dated 11/13/19, included diagnoses of disorders of the bladder, lumbar disc degeneration, disease of the spinal cord, muscle weakness, severe bilateral open angle glaucoma, anemia, diabetes type 2, major depressive disorder, peripheral vascular disorder, rheumatoid arthritis, generalized arthritis, and osteoporosis. During an interview on 11/8/19, at 10:33 a.m. R1 was observed seated in her wheelchair in her room. R1 stated she had been back from the hospital for a few days now however, felt much better, but could not recall why she had been in the hospital. When asked if something happened prior to going to the hospital R1 stated, "I remember the aide that was not nice." When asked, R1 did not know the NA's name. R1 continued, "That aide was never nice to me, she had black braided hair with gold glitter in it, and long fingernails that were curved." When asked why she did not think the NA was nice to her, R1 stated, "She (NA-1) transferred me with a mechanical standing lift and was rough with me. The aide put the calf strap on too tight. When I told her it was too tight, she did not listen." R1 also stated she'd had large bruises all the way down her legs to the floor and stated she had thought NA-1 pulled her hair above her left ear. R1 stated then, "She [NA-1] was washing down there (vaginal area), really hard. She kept doing it when I told her to stop it, she wouldn't quit." R1 had tears in her eyes, looked down, and would	F 600	Executive Director and Director of Nursing will be educated on Abuse Policy and training by Diane Erickson (Quality improvement nurse with Ecumen). 11/12/2019 Review of Abuse Policy and training will be designated for each department head to complete training with their staff on 11/12/2019. Non-direct care facility staff that are not present at the facility 11/12/2019 will be provided with above education prior to their next scheduled shift to work . Documentation will be lead by each department's supervisor, and copy of the training will be then put in each employee's personnel file. 3. Date of Completion: 11/12/2019 4. Recurrence will be prevented by: All staff review of Abuse policy and training completed 11/12/2019 All staff will be provided Abuse policy education & training upon hire and quarterly thereafter All submitted VA reports will be submitted for review to facility nurse consultant or designee prior to the 5 day submission in order to ensure thorough investigation and appropriate interventions are in place to prevent reoccurrence. All VA reports will be reviewed by RDO/RNC or designess prior to	

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F 600	Continued From page 4 not make eye contact but stated, "There wasn't anybody else in the room when she was doing that, I have no witnesses whatsoever. When she was done she [NA-1] kissed me, she was so insistent with herself. I told her to 'get her ass out the door and don't look back'." R1 stated she had reported NA-1 to registered nurse (RN)-A. R1 also stated, "That was not the first time that aide treated me roughly." When asked if she had previously reported any issues with the aide, R1 said she thought she had however, could not remember to who. R1 stated, "This time I was sick of how she (NA-1) treated me. When she got done washing me, it hurt!" R1's physician orders included: Estriol-Estradiol cream, insert 0.5 milligrams vaginally one time a day on Monday and Thursday for urinary tract infection prevention (start date 7/26/19). R1's Progress note dated 10/24/19, at 9:04 p.m. indicated the family member had been informed of the allegation of potential abuse. The note indicated the family had been assured NA-1 was no long in the building, and R1 felt safe. Documentation also indicated it had been explained to R1's family that RN-A and the TMA had spent time with R1 to ensure that she was doing okay emotionally felt safe. R1's Skin Assessments dated 10/18/19 and 10/20/19, verified R1 had no impaired skin integrity (such as bruises, abrasions, or moisture associated skin damage) anywhere, other than a scab on her left outer foot near the heel noted on the 10/20/19 assessment. R1's skin assessment dated 10/24/19, at 7:30 p.m. indicated R1 had pain in peri area and left	F 600	submission for all future occurrences. VA reports will be sent for audit, and will be returned with a summary of the findings. ADM, DON or designee will then review the summary of findings with corrections and adjustments made accordingly. All VA reports will be brought to Quarterly QA for committee review 2 CNA cares will be audited by DON or designee weekly for one month and two biweekly for two months for a total of three months. 5. Correction will be monitored by DON or designee and QAPI committee	

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F 600	Continued From page 5	F 600		

breast. The skin assessment included:
-Right knee (rear) Bruise 1 centimeter (cm) x 1.25 cm
-Right lower leg (rear) bruise 2.0 cm x 1.0 cm
-Abrasion to peri area (did not specify exact location) 6.0 cm x 1.5 cm
-Left breast caught in side rail during transfer (did not describe skin impairment)
-Left outer thigh bruise 1.5 cm x 2.0 cm
-Left side inner knee (below the 1.0 cm x 1.0 cm) bruise 4.5 cm x 4.5 cm
-left side inner knee bruise 1.0 cm x 1.0 cm
-Right back upper knee bruise 1.25 cm x 1.25 cm
-Right below back knee bruise 2.0 cm x 1.75 cm
-Right front side of shin bruise 1.5 cm x 1.0 cm
-Right upper thigh bruise 2.0 cm x 2.0 cm

R1's nursing progress note dated 10/25/19, at 5:37 a.m. included, "When administering residents morning meds this nurse was doing a skin check for bruises and marks that may not have been previously noted. When this nurse asked resident what happened resident stated, "We were talking about racism and she got mad and slapped me three times in the face, my eyes hurt." I then asked what happened to her right knee for it to have so much bruising and resident stated "that happened too."

R1's behavior progress note dated 10/25/19, at 10:03 a.m. included: "[R1's name] continues to be sad about what happened to her. Able to talk about it and redirect." In the section Details of Behavioral Episode?: "Talking about what happened." In the section Potential Causes or Triggers?: "Incident that occurred". In the section, List non-pharmacological interventions attempted/effective?: "Sat with her [R1] and listened and visited with her in regards to what

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F 600	Continued From page 6	F 600		

happened and just small talk."

R1's progress note dated 10/25/19, at 2:48 p.m. indicated R1 had experienced a change in cognition "over period of time today, seen by the physician, and determined [R1] should be sent to the emergency room (ER) for further evaluation." A subsequent progress note at 2:50 p.m. indicated R1 had been transferred to the ER via ambulance. Progress note at 6:19 p.m. indicated RN-A had called the hospital to get an update on R1 and had been informed R1 had a sexual assault nurse team collecting evidence and doing an exam. The hospital nurse reported R1 had 3 abrasions inside her labia and "bruising to both sides of the peri lips." The note further indicated the hospital inquired if the staff member involved in any incident was male or female and was informed it was a female staff member.

R1's progress notes reviewed from 10/11-10/25/19, did not identify R1 had been treated for yeast infection, had complaints of vaginal itching, and/or had impaired skin integrity.

During an interview on 11/8/19, at 10:18 a.m. nursing assistant (NA)-A stated she was very familiar with R1, and worked at the facility full time. NA-A stated R1 used a standing mechanical lift for transfers, had been normally alert and orientated. NA-A stated R1 historically was pleasant and cooperative however, it she felt like she was being ignored or took a long time to answer her call light, she would be more particular when her call light was finally answered. NA-A stated, "She (R1) would have you do more things for her or be picky about how things were done." NA-A stated R1 had never made allegations of abuse before. NA-A stated

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 11/13/2019

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 600	Continued From page 7	F 600		

the morning of 10/24/19, she had washed R1 up and had not noticed any bruises or scratches, and R1 had not complained of any discomfort. NA-A further stated indicated R1 had not complained of vaginal itching and had not seen R1 scratching herself. NA-A stated she thinks she went home around noon that day. NA-A stated she had received a phone call later that evening from registered nurse (RN)-A asking about injuries on R1. NA-A stated the next morning on 10/25/19, R1 was weepy, would not tell her why, and wasn't conversational. NA-A stated she gave R1 a shower and during the shower R1 seemed better. NA-A verified during the shower she noted R1 had bruises on both her legs everywhere, on the front and back, up and down. NA-A stated she thought R1 bruised easily however, had not seen bruising to that extent on R1. NA-A stated after the shower, R1 was brought back to her bed and laid down on her bed, and RN-A came to her room to do a skin check. NA-A also stated she then saw an injury in R1's peri area that was a couple of centimeters long, and stated she had some redness on the labia and in the groin.

During an interview on 11/8/19, at 10:48 a.m. RN-A stated she worked late on 10/24/19, and was asked to do R1's estradiol treatment. RN-A stated R1 was not on a blood thinning medication but when she pulled back the covers she noticed bruises and a mark in the groin area. RN-A said R1 had reported to her "She [NA-1] hurt me". RN-A stated the TMA then came into the room and R1 described the NA who hurt her as the one with sparkles in her hair, R1 told RN-A she told the NA-1 to "get out of here". RN-A stated R1 did not go into detail about what NA-1 had done other than stating during the transfer NA-1 got R1's

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 11/13/2019

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 600	Continued From page 8	F 600		

breast stuck in the bedside rail. RN-A stated she had immediately called the director of nursing who had instructed her to walk NA-1 out of the building. RN-A stated she kind of remembered NA-1 having long fake fancy fingernails on that evening. RN-A stated R1 was lucid, alert and orientated, and did not have bruises and/or vaginal abrasions before 2:00 p.m. on 10/24/19. RN-A stated she had counted 9 bruises and scratches, but the lighting was really bad and had questioned some areas that may have been bruises. RN-A stated she called NA-A to ask if she had seen the injuries earlier in the day, which she had not. RN-A stated she informed family. RN-A stated that night R1 was worried the rough NA [NA-1] was still in the building, was anxious, was provided reassurance that NA-1 was sent home, and eventually R1 settled down. RN-A stated she had not informed the physician on 10/24/19, of the allegation or of R1's bruises. RN-A stated the next morning on 10/25/19, she re-examined R1, and had identified the same injuries in better light. RN-A stated R1 continued to report rough treatment and described NA-1 however, later that morning/day she became less lucid and became very confused. RN-A said due to the cognitive changes, the physician saw R1 that afternoon and R1 was sent to the ER for assessment of the mental status change. RN-A stated, "That's when the emergency room staff called to ask some clarifying questions about [R1's] bruises/injuries." Further, RN-A stated the family member who had been present at the hospital said R1 had reported to the family she had been raped.

During an interview on 11/8/19, at 11:45 a.m. the medical doctor (MD) stated he had seen R1 the following day for a routine visit and that is when it

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 11/13/2019

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 600	Continued From page 9	F 600		

was brought to his attention there had been an allegation of rough treatment. MD stated he did not do a vaginal exam. MD stated he saw fresh bruises on R1's lower extremities that could have been from an aggressive transfer. MD stated he was also aware R1 had a tendency to scratch her peri area, but could not say the injuries were not caused by someone else, and also stated the injuries could have been caused by sharp nails. When the MD was informed of the size of abrasion, as reported by the facility, the MD stated a scratch that size was not likely to have been self-inflicted. The MD stated R1 often had pain during urination, and stated on 10/25/19, R1 was sent to the emergency room (ER) related to new onset of confusion, but testing had not revealed the etiology of confusion.

R1's hospital record indicated R1 was admitted to the hospital on 10/25/19, and was discharged back to the nursing home on 10/31/19.

R1's hospital emergency room record identified R1 had been admitted 10/25/19 at 2:53 p.m.. In the area Reason for Visit, the chief complaint included: "Altered mental status (pt (patient) lives at St. Marks and was brought in by EMS (emergency medical service) for altered mental status. Patient is normally alert and orientated. EMS states nursing home reported a possible abuse allegation against the patient as the victim and hx (history) of UTI (urinary tract infection) recently. Pt denies any pain, VS (vital signs) are WNL (within normal limits)...."

The emergency room physician note dated 10/25/19, at 4:08 p.m. included, "pt was found to have multiple bruises and an abrasion to vagina, when asked, pt stated, 'She [an aide, NA-1] was

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 11/13/2019

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 600	Continued From page 10	F 600		

in a hurry and rough and she has long nails.' The traveling aide whom they believe the patient was talking about was fired and they have an ongoing internal investigation. Patient today also made statements such as 'she slapped me three times in the face.' Pt is unable to give clear account of injuries ...At this time it was decided that pt could benefit from admission to the hospital for further work up of hypoxia, AMS (altered mental status) and abuse."

The emergency room physician note dated 10/25/19, at 6:02 p.m. indicated EMS reported R1 underwent a harsh bed transfer by a caregiver at the nursing home. " ...there were lesions on inner labial wall and clitoral hood. I think evaluation by SANE (sexual assault nurse evaluation) staff to better delineate the physical findings ..."

An emergency room nursing note dated 10/25/19, at 7:23 p.m. included: "This nurse spoke to [nurse from nursing home RN-A]....According to [RN-A] there was an 'incident' last evening. [RN-A] went further into detail that last evening a travel nurse aide [NA-1] was 'getting rough' with [R1] while doing her cares. She reports the travel aide had long nails and cut a little on patient's perineum are and gave patient bruises on bilateral legs while doing cares. This travel aide was fired immediately and escorted out of the building and [RN-A] stated they opened up a report'. No indication further of what the travel aides name was, if law enforcement was called, and did not state any further injuries to the patient. When nurse, nursing assistant [at ER] were to obtain a urine sample from patient using a straight in and out catheter, after cleaning the area to prepare for the procedure there were abrasions noticed inside the labia (minimum of 3)

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 11/13/2019

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 600	Continued From page 11	F 600		

and what looked like discoloration/bruising outside of the genitalia. ER provider was notified and did an assessment when nurse was told to halt any further urine sample obtained and call daughter for consent to do an exam, to which daughter agreed." The note indicated an exam by SANE nurses was requested and a report was filed with the county. The note further included: "Patient doesn't know what happened to her but states its from her husband (who is deceased)...has altered mental status as of today." Further the note indicated RN-A from the facility had informed the ER nurse the resident's allegations were against a female staff. When the ER nurse asked RN-A whether she had examined R1, RN-A had informed the ER nurse she had, and R1 had a small scratch on the outside of the perineum. The ER nurse then told RN-A, "while trying to obtain a urine specimen, staff noticed discoloration/bruising outside the perineum and a few abrasions inside of the labia." The not further indicated the ER nurse had notified RN-A the ER staff had reported the incident to the county.

Photos, and documentation of the sexual assault nursing evaluation from the ER dated 10/25/19, at 6:15 p.m. identified the following injuries without measurements:
1) Contusion on right lateral calf
2) Contusion to top of the right shin
3) Contusion on right inner/lower knee
4) Contusion on right inner/upper knee
5) Contusion on right outer/lower knee
6) Left outer foot noted dressing in place
7) Contusion on left center below knee
8) Contusion on left outer posterior knee
9) Contusion on left outer posterior knee
10) Contusion on left outer above knee

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 11/13/2019

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 600	Continued From page 12 11) Contusion on left wrist 12) Right labia majora, raised discolored linear injury 13) Left labia majora, raised discolored linear injury 14) Right posterior medial gluteal fold: linear excoriation, bright red; raised and welted 15) Left posterior medial gluteal fold; linear excoriation, bright red in color, raised and welted 16) Along and inside vaginal wall: small reddened areas circumferential that patient indicates tenderness 17) Labia minora; abrasions 18) Tissue surrounding clitoris; reddened area with superficial tissue injury that patient indicates great tenderness. Sexual assault evaluation note dated 10/25/19, at 9:22 p.m. included: "During exam patient repeats that she was abused, but remains unable to communicate how it occurred. Injuries noted and recorded on bilateral lower extremities. No open areas visualized. Injuries noted and recorded to genital/perineal area. Of note that tissue surrounding these injured areas is clean/dry/intact no maceration noted. Unable to appreciate any identifiable contributing factors such as dry skin/rash and patient denies itching." The note also indicated report and evidence was provided to law enforcement. R1's hospital social worker note dated 10/28/19, indicated the reason for social worker referral was "discharge planning, suspected abuse or neglect." The note included: "There was a report of abuse and the appropriate person was notified, spoke with [name of family member] extensively and she wants [R1] to return to the nursing home. The person suspected of abuse is no longer	F 600		

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 11/13/2019

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 600	Continued From page 13	F 600		

employed." The note indicated R1 would return to St. Marks.

A police report dated 10/27/19, indicated a detective went to the hospital on 10/25/19, to investigate suspicious injuries on R1, and had interviewed SANE nurses. The report included statements from the SANE nurse including: "Possible skin injury consistent with abuse on her clitoris, [R1] had abrasions inside of her vulva, [R1] also had abrasions in her vaginal wall. [Name of nurse] stated that these injuries are not consistent with normal injuries that an elderly patient would receive from normal activities." The report also indicated the injuries on R1's body were relatively recent and evidence was collected. The police report did not identify any conclusion of facts, or whether the case was considered resolved or closed.

Upon review of the facility's internal Investigative Summary submitted to the State Agency on 11/1/19, at 4:26 p.m. the facility's Investigative Summary was noted to be inconsistent with hospital documents and other notes in the resident's record.

On 11/8/19 at 1:20 p.m., NA-1 was interviewed regarding the allegation of abuse. NA-1 stated in an angry tone of voice, "They investigated it at the facility, I was cleared! They let me come back to work!" NA-1 stated the facility had told her they had talked to several people, and had determined the resident involved had previously made allegations about having been abused. NA-1 stated, "They told me I was cleared and the allegation was wrong." NA-1 also stated she had worked a 16 hour shift on 10/28/19, but was no longer working at the facility due to a facility

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 11/13/2019

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 600	Continued From page 14	F 600		

nurse having reported she (NA-1) was mean to her. NA-1 said, "The facility ended my contract the next day (10/29/19)." During the interview, NA-1 verified she had been suspended on 10/24/19, and had remained on suspension on 10/25, 10/26, and 10/27/19. When asked to describe what happened on 10/24/19, NA-1 stated she wore her hair in a braid and during provision of cares, R1 had asked her if she was a thug. NA-1 stated she had transferred R1 to a commode and had washed R1's perineum from behind her while R1 was on the commode. NA-1 stated, "I must have wiped her too hard between her legs. She said 'ouch'." NA-1 stated she hadn't meant to wipe R1 to make her sore, but stated when she had looked at R1's perineum, "She was a little red." NA-1 said she had then put R1 to bed. When NA-1 was asked whether she had noticed any bruises on R1's legs, or abrasions in R1's perineum area, NA-1 yelled, "I didn't do anything wrong, I don't wear nails to work. I keep my nails short when I have to work!" NA-1 then verified she had seen bruises, but stated the bruising had looked old. NA-1 also stated that was only the second time she had assisted with R1's cares.

During interview with the director of nursing (DON) and administrator on 11/8/19 at 2:46 p.m., they were asked how they had concluded there had been no abuse or assault to R1, in order to allow NA-1 to return to work Monday 10/28/19. The DON stated they'd taken into consideration R1's report of somebody treating her rough, her description of the aide, and her injuries and stated: "Once we had looked into all the pieces, which the hospital did as well, it was determined by myself and the hospital staff the scratches were caused by the resident." In addition, the

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 11/13/2019

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 600	Continued From page 15	F 600		

DON stated, "The ER nurse had thought the scratches could have been a result of sexual assault so they did a SANE and sexual assault kit." However, the DON stated, "The facility staff had not considered that [R1] had been sexually abused because there was no report of that, and we had not seen any physical signs of sexual abuse." The DON reiterated the reason R1 had been transferred to the ER was for evaluation of a change in mental status and decline, which the physician had felt was likely related to hyponatremia and/or an urinary tract infection.The DON stated, "On Thursday 10/24/19, [R1] had reported [NA-1] was rough with her and we reported it to the State Agency. She (R1) continued to have changes in baseline mental status like seeing things and people that were not there. When the hospital nurse went to insert a catheter for urine specimen they discovered the injuries. The hospital informed us they were going to make a report to the State Agency for physical and sexual abuse, and as a result the police became involved in the investigation. What I was told from the hospital and police, the result from the SANE evaluation and sexual assault kit were unsubstantiated. I was also told from the hospital staff and investigator [family member], the resident had continuously described a different person. The original NA [R1] had reported was black and had sparkle in her hair with long black braids. When she [R1] reported to the investigator she reported it was a short white women with blonde hair that wore a lot of jewelry. No staff members fits that description." The DON further stated that throughout R1's hospital stay it was continuously reported that R1 had suffered delusions and hallucinations. "We had determined the bruising was not a result of abuse, bruising patterns were

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 11/13/2019

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 600	Continued From page 16	F 600		

not consistent with somebody being rough." The DON stated during interview with NA-1, NA-1 had explained she had toileted R1, assisted with wiping her peri area, had stopped because she noticed redness, then adjusted how she cleansed R1. The DON stated NA-1 had reported that R1 was fine at the time, but had been sore when she had wiped her. DON stated overall the physical attributes did not present as being caused by rough care stating, "Her [R1] continued confusion and delusion all pointed to abuse or rough treatment not having actually occurred." The DON also stated the police had come to the facility during their investigation and interviewed other staff members, and the officer had informed her they had finished their investigation. The DON stated she had been informed in person, from the police detective, the abuse allegation was not substantiated, and therefore there was no reason to continue their internal investigation or keep NA-1 off the schedule. The DON stated she had not been provided with a written police report and/or conclusion, but reiterated based on the interviews with hospital staff, the police investigator, and their own facility investigation, the determination was made abuse did not occur. The DON further verified she had no record and/or documentation of any conversations with hospital staff or the police detective. The DON said she personally watched a transfer prior to R1 going to the hospital and stated, "The way [R1's] legs were hitting the FEZ Stand, it looked liked the the bruises were from being bumped from transfer or bumping into something. The location the shape of them, did not look like bruises from a hand mark."

During an interview on 11/8/19, at 1:41 p.m. the emergency room RN, (ER)-B, stated she

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 11/13/2019

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 600	Continued From page 17	F 600		

remembered R1 coming into the emergency room from St. Marks. ER-B stated she remembered R1 was brought in due to changes in mental status and not for further evaluations of assault however, stated the ER staff had been informed by the ambulance crew of allegations of rough treatment/abuse from the previous night. ER-B stated when the physician and nurses went to insert a catheter to collect a urine specimen, they discovered vaginal abrasions and organized bruise patterns on R1's perineum internally, and externally, which was not consistent with what would be expected from chaffing or other skin injury associated with moisture. ER-B stated R1 had reported to ER-A she had been abused. ER-B stated, "Upon discovery of the injuries we had a sexual assault nurse examination (SANE) completed, they completed vaginal swabs for lab testing."

During an interview on 11/8/19, at 3:07 p.m. the hospital's sexual assault nurse examiner (SANE) -A, stated she remembered R1, and had assisted with R1's examination. SANE-A stated during the exam R1 had been pretty alert and orientated however had some confusion. SANE-A stated R1 had been cooperative, agreeable, "definitely consented to the exam" and was quiet during the exam. SANE-A stated there was one vaginal internal injury and stated R1, "Had extensive bruising in the genital area." SANE-A further stated regarding the abrasions in R1's vaginal area, "We wouldn't see what we saw from scratching or from self-infliction." SANE-A stated R1 did not have any signs of yeast infection and/or other signs of skin breakdown. SANE-A stated R1 did not complain of vaginal itching and did not attempt to scratch herself. SANE-A also stated SANE nurses gather and record evidence

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 11/13/2019

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 600	Continued From page 18	F 600		

but did not make conclusions. SANE-A stated she had not had any contact with the family and/or the facility.

During an interview on 11/8/19, at 3:31 p.m. SANE-B stated she remembered R1, and had performed the examination with SANE-A. SANE-B stated R1 had been transferred from the nursing home because of altered mental status, and SANE nurses were called because of an allegation R1 had been assaulted. SANE-B stated R1 presented with some lower extremity bumps and bruises that could have been caused by regular activity that were not all that concerning. However, SANE-B stated R1 also had vaginal injuries. SANE-B stated, "I don't know if the injuries had been caused by sexual abuse, but there was obviously trauma." SANE-B stated R1's peri-area skin had not appeared red and/or raw, and nothing that indicated that R1 had a yeast infection. SANE-B stated R1's vaginal injuries were well defined and were localized to the genital area. SANE-B stated, "We asked [R1] if it hurt. [R1] could tell us she wanted help, she wanted the police, and she told us she had been hurt." SANE-B stated she had gotten the report that a traveling nursing assistant had caused the injuries and had been escorted out of the nursing home. SANE-B stated, "[R1's] injuries were not consistent with itching, scratching, or self-infliction." However, SANE-B verified she could not confirm what caused R1's injuries adding, "[R1] suffered some kind of trauma and had traumatic injuries. I can't imagine you would be able to traumatize that area without knowing it, that area is quite tender, and a very sensitive area of the body. We can't say it was sexual abuse, but the injuries were consistent with trauma, those were traumatic injuries." SANE-B

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	245369	A. BUILDING _____ B. WING _____	C 11/13/2019

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

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F 600	Continued From page 19	F 600		

stated in her professional judgement and experience R1's injuries were consistent with some type of abuse however, again stated, "It is not our role to determine what or who caused the injuries." Instead, SANE-B stated the role of the SANE was to complete the physical assessment and provide police with evidence. SANE-B indicated after the exam, they made sure that a report had been made to the State Agency for suspicion of sexual and/or physical abuse. SANE-B indicated after a traumatic experience the first 24-48's the victim has a very difficult time recalling information, which could have been a contributor to R1's confusion however, acknowledged R1 had other clinical things going on that could have caused the sudden onset of confusion as well. SANE-B verified she had not had any contact with the facility and/or family.

During an interview on 11/8/19, at 4:04 p.m. ER-A stated she remembered R1 coming into the emergency room for altered mental status, that R1 had normally been alert and orientated to person, place, and time, but was now only alert to person. ER-A stated the ambulance driver had mentioned that R1 had been physically assaulted by a staff member at St. Mark's, something had happened, and the staff member had been fired and walked off the property. ER-A stated the transfer form had not mentioned anything about allegations of abuse so she called the facility to get more information. ER-A said, "The facility nurse (RN-A) told me [R1] had been physically assaulted the night before by a prior aide, the aide had been really rough with [R1] while getting her ready for bed. [RN-A] reported [R1] had bruising to her legs and one scratch around perineal area, and that the aide had long finger nails." ER-A added, "The facility chose not to

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	245369	A. BUILDING _____ B. WING _____	C 11/13/2019

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F 600	Continued From page 20	F 600		

send [R1] into the hospital at the time of the incident for further examination of her injuries, but they should have, given the extent of her injuries." ER-A stated after she received the information from the nurse, she had to catheterize R1 to obtain a urine sample however, upon removal of R1's incontinent garment she immediately saw R1's injuries, which was more than what the facility nurse had mentioned. ER-A stated, "I saw bruising on the outside of the vaginal opening, bruising in the thighs, there was 2-3 abrasions inside the labia." ER-A stated R1 had been crying, so ER-A could not recall if R1 had voiced pain while in the ER. ER-A stated she immediately informed the ER doctor who obtained consent from R1 and R1's family to perform a SANE. ER-A stated she then called RN-A back to inquire when R1 had last had a bath or shower. ER-A said RN-A informed her R1 had a shower that day, which ER-A said "should not have been done". ER-A also said RN-A had stated the alleged abuser was a a traveling NA. ER-A stated she had informed RN-A that R1 was referred to the SANE nurses for further evaluation, the police were going to be contacted, and a vulnerable adult report was going to be submitted to the State Agency. ER-A indicated photos were taken and entered into the record. RN-A stated aside from R1's injuries, R1's perineal area was clean, dry and intact, and there was no signs of yeast infection. "[R1] was not scratching or itching and offered no complaints of itching." ER-A stated after her conversation with RN-A, she had not had any other contact with the facility. ER-A stated after the SANE, R1's physician was informed of the findings.

During a subsequent interview on 11/8/19, at 5:19 p.m. with the DON and administrator, the DON

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 11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 21	F 600		

reiterated, "Based on the facility's investigation, abuse was not substantiated related to [R1's] confusion." The DON also stated R1 was being treated for a yeast infection and the injuries to R1's genital area were likely self-infected. The DON stated she had talked to several nurses at the hospital during the investigation however, did not recall their names and did not write the names down. The DON also stated she had reviewed R1's hospital nursing notes from the time she went into the ER. The DON stated the notes indicated R1's injuries were a result of scratching herself. The DON was asked to review R1's physician orders and treatment administration records to verify whether R1's physician orders and/or treatment included yeast infection treatment. The DON confirmed R1 did not have any treatment order for yeast. The DON was asked to access online hospital progress notes that were used, the DON was not able to access R1's record but stated she was aware the hospital locks the records during abuse investigations. The DON then stated she must have obtained the information from the discharge referral portal that included R1's discharge summary. The DON verified after the facility had conducted their investigation, NA-1 was allowed to resume her scheduled work hours on 10/28/19. At this time, the administrator confirmed re-education was only provided to NA-1, not any of the other staff, because no other staff were involved.

During an interview on 11/9/19, family member (FM)-A stated she had been immediately informed of the allegation of rough treatment on 10/24/19. FM-A stated the facility told her NA-1's employment had been terminated. FM-A stated she was not aware NA-1 had been cleared of any

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F 600	Continued From page 22	F 600		

wrong doing, and was not aware NA-1 had returned to work on 10/28/19. FM-A stated she had not been informed of any investigation conclusions by the hospital, nursing home, or the police detective. FM-A stated she had not been informed of the extent of R1's injuries until she got to the emergency room on 10/25/19, when the physician asked for consent for a sexual assault evaluation because of the injuries. FM-A stated the facility informed her it had been determined R1's vaginal injuries were caused from R1 scratching herself, and was not aware how that was determined. FM-A stated the DON had informed her the bruises on R1's legs were sustained as a result of a transfers because of her posture and that she had perhaps bumped on something during a transfer. FM-A stated normally R1 had been historically sharper than a tact, but in the last couple of months R1 intermittently had episodes of confusion, but nothing really notable until 10/25/19. FM-A stated on 10/25/19, R1 was very confused and disoriented. FM-A stated R1 had not reported to her anything about what had happened to her but thought she did not do so because she didn't want to burden family members with worries. FM-A also stated R1 was probably embarrassed and didn't want FM-A to know.

During an interview on 11/9/19, at 2:50 p.m. a hospital medical surgical registered nurse (HRN) -A stated she remembered R1 and knew her from when she used to work at St. Marks. HRN-A stated R1's mental status would change when she had an infection, and stated R1 would become very confused. HRN-A stated R1's mental status got worse during her hospitalization, she was having delusions and hallucinations and was talking to people that were

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F 600	Continued From page 23	F 600		

not there. HRN-A stated the police detectives and physicians tried to get information however, R1 was all over the place with answers and was hallucinating. HRN-A also stated she had seen R1's bruises and in her professional experience and opinion, the bruising was caused by rough treatment and poor care. HRN-A stated she had not seen R1's injuries to her vaginal area, but when she had tried to clean R1 after an incontinent episode, R1 had stated "Please don't do it, stop!" HRN-A stated that was not typical behavior from R1, stating, "Her not allowing herself to be cleaned, was really different." HRN-A stated to her knowledge, R1 had not been treated for yeast infection.

During an interview on 11/9/19, at 2:57 p.m. HRN-B stated she had provided care to R1 during her hospitalization and remembered R1. HRN-B stated she had not had any contact with anyone from the facility during R1's hospitalization. HRN-B stated when she cared for R1, R1 displayed "sun downing" symptoms and had her days and nights mixed up. HRN-B stated R1 had hallucinations and was disorientated during the evening shift but then would seem fine during day shift. HRN-B stated she did not see R1's bruising or vaginal injuries, R1 was not treated for a yeast infection, and R1 did not complain of any symptoms of a yeast infection. HRN-B stated based on radiology reports there was a tear in the vaginal area (inside), which the gynecologist thought could have been a scratch, and did not think was from sexual abuse. HRN-B stated to her knowledge, the responsible aide (NA-1) was no longer working at the facility. HRN-B stated, "Had we known that aide (NA-1) was still there, the discharge plan would have changed. The hospital would not have discharged [R1] back to

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F 600	Continued From page 24	F 600		

the facility, we would have looked for an alternative."

During an interview on 11/9/19, at 3:12 p.m. HRN-C stated she had seen abrasions in R1's perineal area during her hospitalization. HRN-C stated R1 had not been treated for a yeast infection during hospitalization, and had not been scratching and/or complaining of itching. HRN-C stated R1 had been lucid at times and confused at other times. HRN-C stated she was not aware of what caused the trauma to the area. HRN-C stated she had not had any conversations with staff from St. Mark's.

During an interview on 11/9/19, at 3:28 p.m. HRN-D stated she remembered R1. HRN-D stated nurses were directed not to give any information to St. Mark's pertaining to R1 because there was an ongoing vulnerable adult investigation. HRN-D stated R1 had been pleasant during the shift she'd worked, and stated she remembered R1 being concerned about whether she had any marks on her bottom. HRN-D also verified R1 had not been treated for a yeast infection, had not been itching, and had not had complaints of vaginal itching.

The facility's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 3/14/18, included: ..."all residents, including vulnerable adults residing in the facility will be protected from abuse, neglect, misappropriation of property, exploitation, maltreatment and mistreatment ... Injuries of Unknown Source, must be reported if the injury in suspicious because of the extent of the injury or location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of

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F 600	Continued From page 25	F 600		

injuries observed at one particular point in time or the incidence of injuries over time." Further, the policy indicated injuries of unknown origin required investigation whether reported to the State Agency or not. The policy included: "Components of Abuse Prevention, The facility will develop and operationalize policies and procedures for screening, training, protection of residents, and for the protection of residents, and for the prevention, identification, reporting of maltreatment/mistreatment. Prevention- At the time of admission, residents and responsible parties will be informed of resident rights, the facility's zero tolerance for maltreatment/mistreatment. Investigation and Reporting of Maltreatment/Mistreatment following an incident. Incidents, including but not limited to injury, fall, elopement, bruise or other injury of unknown origin, unusual happening, abuse, or any other maltreatment/mistreatment involving a resident are to be reported, documented, and investigated. The administrator or Administrator's designee is responsible for ensuring that an internal investigation is completed and the results are reported to the OHFC (office of health facility complaints, the State Agency). The investigation of the report will be conducted by the appropriate personnel, and a report of the investigation will be submitted to the administrator and to OHFC. It is imperative that staff fully cooperate during investigation. Appropriate controls will be put into place to prevent accused individuals from having unsupervised contact with the resident. If the accused individual is an employee, contractor, or volunteer, said individual will be removed from the facility pending investigation. The administrator or designee will keep the resident and resident's representative informed of the progress of the investigation, and the

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F 600	Continued From page 26 investigation findings. All persons, including residents, an alleged perpetrator and employees shall be protected from harm during the investigation. The facility shall prevent further potential abuse, neglect, exploitation, or mistreatment, and ensure the resident's psychosocial well-being as related to the incident under investigation, while the investigation is in progress." The IJ that began on 10/24/19, was removed on 11/13/19, when a removal plan had been approved, and implemented: The facility's leadership reviewed policies and procedures and reporting documentation; policies and procedures were made available at the nursing stations; all staff completed abuse training; all nursing staff were interviewed to determine their knowledge of signs/symptoms of abuse; and the provider had developed of an auditing system as part of their quality assurance plan.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2019

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

Re: Event ID: OBI811

Dear Administrator:

The above facility survey was completed on November 13, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 11/13/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On 11/8/19 through 11/13/19, surveyors of this Department's staff conducted an complaint investigation. There are no corrections orders issued. Complaints investigated were: H5369083C substantiated H5369084C not substantiated Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		