DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2020

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

RE: CCN: 245369
Cycle Start Date: August 19, 2020

Dear Administrator:

On September 1, 2020, we informed you of imposed enforcement remedies.

On NO DATA, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed: (pick one or add according to CMS Letter and delete this note or delete this blue section if no CMS letter)

- Directed plan of correction, Federal regulations at 42 CFR § 488.424 Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 1, 2020.

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 19, 2020. (42 CFR 488.417 (b))

On September 3, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 1, 2020, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 1, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 1, 2020.

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

As we notified you in our letter of September 1, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 1, 2020.

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, Unit Supervisor
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: 507-206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 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.

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 09/03/2020

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 8/31/2020 thru 9/3/2020 an 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 following complaints were found to be SUBSTANTIATED: H5369093C was substantiated with no deficiencies H5369095C was substantiated with no deficiencies H5369096C was substantiated with a deficiency at F656 H5369094C was substantiated with a defiency at F695, F849 The following complaints were NOT substantiated: H5369097C was not substantiated, however an associated deficiency was identified and issued at F713 H5369092C 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	F 000		

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

Electronically Signed | 10/02/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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	Continued From page 1 conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 656	Continued From page 2 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for anticoagulation for 2 of 3 residents (R5 and R6) for anticoagulation management. Findings include R5 R5's Admission Record dated 9/3/2020, indicated R5 was admitted to the facility on 3/5/2020 with diagnoses that included long term use of anticoagulants and therapeutic drug level monitoring and was discharged from the facility on 4/1/2020. R5's hospital after visit summary (AVS) dated 3/5/2020, included general information/education pertaining to prevention of venous thrombosis prevention, and signs and symptoms of bleeding related to anticoagulant use. The AVS also identified R5's INR (international ratio- lab that measures blood viscosity) goal range was 2.0 to 2.5. R5's admission Minimum Data Set (MDS) dated 3/11/2020, indicated R5 required anticoagulant medications.	F 656	Corrective Action R5 discharged the facility on 4/1/20. R6 care plan has been updated to include goals & interventions for anticoagulation management that identified risk for bleeding and goals & interventions for therapy. Action completed on: 9/20/2020 Corrective Action as it applies to all residents: In-house audit was completed on all residents who currently are on anticoagulants. Audit included ensuring that each resident has a current care plan that includes goals & interventions for anticoagulation management. Audit was completed on 9/30/20. All nursing leadership was educated on anticoagulation management on 10/2/20. Anticoagulation management was added to the nurse managers care plan checklist and a separate coumadin order entry checklist was created and implemented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 656	Continued From page 3 R5's admission orders included Coumadin (anticoagulant medication) 1.5 milligrams (mg) every day on 3/5, 3/6, 3/7, 3/8 and INR on 3/9/2020. R5's care plan dated 3/18/2020 did not identify a plan of care with goals and interventions for anticoagulation management that were outlined in the hospital (AVS). R6 R6's Admission Record dated 9/3/2020, included diagnoses of history of venous thrombosis (blood clot) and long term use of anticoagulants. R6's annual Minimum Data Set (MDS) dated 7/25/2020, indicated R6 did not have cognitive impairment and required anticoagulant medications. R6's physician orders included: Coumadin (anticoagulant medication) 1 milligram (mg) every evening on Monday, Wednesday, and Friday and 2 mg every Tuesday, Thursday, Saturday, and Sunday until 9/23/2020 (order start date 8/28/2020) R6's care plan dated 9/9/2019, indicated R6 had a history deep vein thrombosis (DVT); the care plan identified interventions for blood clots however, did not identity R6's risk for bleeding, goals and interventions for anticoagulation management. The care plan also identified R6 was at high risk for falls. During an observation and interview on 9/2/2020, at 10:15 a.m. R6 sat in her wheelchair in her room. R1 stated she took Coumadin; she was not	F 656	on 10/2/20. Date of Compliance: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will ensure that each resident on anticoagulants has an updated plan of care identifying goals and interventions. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 656	Continued From page 4	F 656		

aware of her last International Ratio (INR), (lab that measures viscosity of blood) and stated she wished staff would communicate that to her. R6 stated she bruised easily. R6 then lifted up her shirt to expose her abdomen which revealed two dime sized light purple bruises; R6 stated they were from insulin injections.

During an interview on 9/3/2020, at 1:13 p.m. director of nursing (DON) indicated awareness of R5 and R6's records and stated there should have been a care plan developed for anticoagulation therapy that identified risk for bleeding, goals and interventions of the therapy.

Facility policy Care Planning-Interdisciplinary Team policy dated 9/2013 included: Our facility's Care Planning Team is responsible for the development of an individualized comprehensive care plan for each resident. 1) A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).

Facility policy Care Plans, Comprehensive Person Centered policy dated 2/2020 included: A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person centered care plan will: Include measurable objectives and timeframe's. Describe services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Incorporate identified problems areas. Incorporate risk factors associated with identified problems. reflect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 656	Continued From page 5 treatment goals, timetables and objectives in measurable outcomes. Areas of concern that are identified during the resident assessment will be evaluated for before interventions are added to the care plan.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to consistently assess, monitor, and evaluate oxygen therapy and failed to monitor and evaluate effectiveness of antibiotic prescribed for respiratory illness for 1 of 3 residents (R4) reviewed for oxygen therapy. Findings include During an interview on 8/31/2020, at 10:58 a.m. RN-B indicated R4's oxygen usage was not being monitored or administered appropriately. RN-B stated a couple of weeks ago a trained medication assistant (TMA) removed R4's oxygen without a licensed nurse completing an assessment to determine if the oxygen could be removed. RN-B stated R4's oxygen saturations (Sp02) were below 90% when she checked (could not remember the exact value), RN-B	F 695	Corrective Action R4 oxygen order was changed on 09/4/20 to clarify oxygen orders and add parameters. R4 deceased on 09/19/20. Corrective Action as it applies to all residents: All CNA / TMA were educated on nursing scopes of practice and oxygen usage. Education was completed on 9/10/20. All nurses were educated on nursing scopes of practice, oxygen usage and notifications to providers and hospice. Education was completed on 09/24/20. In-house audit was completed on all	10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 6 stated she provided education to the TMA and reapplied the oxygen. RN-B stated an hour and ten minutes later when she had gone back into the room to check on R4, the TMA had again removed the oxygen without first notifying her to complete a respiratory assessment to ensure oxygen could be safely removed, R4's oxygen saturation at that time was 85%. RN-B stated she completed an assessment to determine what may have caused the decrease, notified hospice nurse, and documented the episode. RN-B stated the finger pulse oximeter doesn't always work appropriately; more accurate readings were obtained from the ear meter. RN-B indicated she didn't think that was on the care plan. R4's Admission Record dated 9/3/2020, included diagnoses of palliative care encounter, dysphagia, dementia with behavioral disturbance, and dependence on supplemental oxygen. R4's quarterly Minimum Data Set (MDS) dated 7/16/2020, identified R4's decision making capacity for tasks of daily life was severely impaired and did not have rejection of care behaviors. The MDS indicated R4 required extensive assistance from two or more staff for bed mobility, toilet use, and personal hygiene. The MDS indicated R4 did not require oxygen therapy. R4's physician orders included the following: -Augmentin suspension reconstituted (antibiotic medication) 400/57 mg/ml (milligram/milliliter); give 6 ml by mouth three times a day for aspiration pneumonia (start date 8/28/2020) -Oxygen (02) via nasal cannula at 1-4 L/min (liters per minute) as needed for comfort and	F 695	residents who have oxygen orders. Audit included ensuring that each resident has parameters in place for oxygen usage, each resident has a current care plan that includes appropriate goals & interventions for oxygen utilization and each resident has supplemental documentation in place for oxygen use. Audit was completed on 10/5/20. Communication was completed with the Hospice Supervisor on 10/2/20 regarding the facility's expectation of receiving hospice documentation in a timely manner. Facility's health unit coordinator or designee will monitor weekly to ensure compliance. Date of Completion: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will ensure that each resident on oxygen has an updated plan of care identifying goals and interventions, and oxygen parameters in place. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 7 shortness of breath (start date 10/28/19). R4's record lacked evidence of a coordinated care plan with the hospice agency. R4's facility care plan lacked a plan of care that included goals and interventions for oxygen usage for respiratory management. However, the care plan dated 3/19/2020 did identify R4 was at risk for COVID-19 infection which included the following interventions that directed the following: -Frequent monitoring and documentation of for signs and symptoms of respiratory infection. Indicated if upon evaluation there was new cough, abnormal lung sounds, or shortness of breath immediate physician notification was warranted. -Report symptoms of suspected respiratory infection to physician, infection preventionist, resident, and resident representative. During an observation on 8/31/2020, at 4:00 p.m. R4 sat in her wheelchair in her doorway with oxygen on via nasal cannula; flow rate was 2L/min. R4's nasal cannula was not placed all the way into her nares; R4's breathing was easy and not labored. During an observation on 9/1/2020, at 9:00 a.m. R4 sat in her wheelchair without oxygen on; the tubing was observed on the floor next to the wheelchair with the concentrator on 2L/min. R4's respirations were easy and not labored. At 9:02 a.m. an unidentified nursing assistant reapplied the nasal cannula without checking Sp02 or notifying the nurse for assessment. Physician visit dated 7/7/2020, included "no vitals taken during this visit" and had no mention of	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 8 oxygen usage. R4's medication administration record (MAR) identified the order for PRN (as needed) oxygen, however the MAR did not identify that R4 required oxygen administration. R4's treatment administration record (TAR) included order to "Screen for any difficulty breathing, shortness of breath, cough, sore throat, persistent pain or pressure in the chest, and fever. Note any additional symptoms of chills, muscle pain, sore throat, new loss of taste or smell, GI symptoms every shift for COVID-19 screening indicate 'Yes' if any symptoms and notify supervisor. The documentation included boxes for documentation of "yes or no", temperature, pulse, and oxygen saturations however, did not include documentation of lung sounds or respiratory rate. R4's oxygen saturation record reviewed from 7/14/2020 to 9/1/2020 was cross referenced with progress notes, treatment administration record, and respiratory rate documentation. The Sp02 record identified documented saturations below 90%; the record lacked evidence of consistent completed respiratory assessments, and implementation of interventions to correct R4's 02 levels when they were low. In addition the record did not identify the amount of oxygen delivered when it was used. Examples included: -7/16/2020- Sp02 89% on room air -7/17/2020-Sp02 88% on room air -7/21/2020, at 3:28 p.m.-Sp02 85% oxygen via nasal cannula (amount of oxygen was not identified). The record indicated Sp02 was rechecked more than 2 hours later at 5:40 p.m.;	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 9	F 695		

Sp02 at that time was 95% on room air.
-R4's corresponding progress note dated 7/21/2020, at 3:00 p.m. included: "Author did v/s [vital sign] check with concerns for decline in health status. O2Sats are 83, 73, 81, 85, 69, fluctuating ongoing. Cont. to monitor". The record lacked evidence hospice and/or physician was notified and lacked documentation of monitoring.
-7/22/2020, Sp02 88% on room air
-7/23/2020, Sp02 88% on room air
-7/29/2020, at 10:08 a.m. Sp02 85% on room air, at 7:58 p.m. Sp02 was 89% on room air.
-7/31/2020, at 9:57 a.m. Sp02 83% on room air. At 4:43 p.m. Sp02 was 98% on oxygen visa nasal cannula (amount of oxygen was not identified)
-R4's corresponding progress note dated 7/31/2020 at 10:31 a.m. included "Spoke to hospice regarding continued perfusion in the mid to upper 80's. Informed them we are titrating 02 up to maintain the mid to low 90's.. Hospice nurse requesting that a return phone call be made to her if her 02 levels do not get to optimal levels. Call with any further concerns."
-8/8/2020, Sp02 89% on room air
-8/26/2020, Sp02 88% on room air

R4's progress note dated 8/28/2020, indicated R4's power of attorney was notified R4 started antibiotic course of Augmentin for aspiration pneumonia. Prior to 8/28/2020 the record did not identify documented signs and/or symptoms of aspiration pneumonia or physician notification. In addition R4's record lacked ongoing assessment for side effects and effectiveness of antibiotic.

During an interview on 8/31/2020, at 9:41 p.m. registered nurse (RN)-C indicated R4 required oxygen as needed, stated oxygen was applied to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 10	F 695		

resident's whose Sp02 was below 90% and would apply appropriate level of oxygen based on the respiratory assessment which included lung sounds, respiratory rate, shortness of breath, heart rate, Sp02 levels. RN-C stated an unawareness R4 was on an antibiotic for aspiration pneumonia; stated respiratory assessments needed to be completed to determine effectiveness of antibiotic.

During an interview on 9/1/2020, at 9:10 a.m. NA-A stated, "I don't know if she is supposed to have oxygen on all the time, they never really tell us." Nursing assistant (NA)-C stated an unawareness if R4 had to wear oxygen all the time.

During an interview on 9/1/2020, at 9:27 a.m. licensed practical nurse (LPN)-B stated R4 was not supposed to have oxygen on all the time, it was as needed and on at night. LPN-B stated an assessment was supposed to be completed prior to putting oxygen on and prior to removing. LPN-B indicated when oxygen saturation were low, oxygen would be applied and would reevaluated for effectiveness. LPN-B verified the physician order did not identify goal range for R4's oxygen saturations. LPN-B stated the antibiotic was prescribed as a prophylactic because R4 had a history of aspiration pneumonia. LPN-B stated a couple of days ago upon respiratory assessment, R4 had adventitious lung sounds and lungs were really diminished at the bases; LPN-B stated he did not document the assessment in R4's record but documented the information on a communication sheet for shift report. LPN-B stated a full respiratory assessment included lung sounds,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 11	F 695		

respiratory rate, and Sp02; the assessments should be completed every shift and documented in the record.

During an interview on 9/1/2020, at 1:22 p.m. TMA-A stated he would check oxygen saturations prior to administering, stated if saturations were low he would apply 2L of oxygen, "recheck every two hours like the order says" and notify the nurse, then the nurse would complete the assessment.

During an interview on 9/1/2020, at 1:47 p.m. NA-B stated R4 did not use oxygen all the time and it was as needed for shortness of breath; R4 could have 1-4 L and the nurse managers determined a goal range for oxygen saturations. NA-B stated she would take R4's O2 saturations and if they were low would apply 2L of oxygen. NA-B stated she would then go tell the nurse and recheck the 02 levels every couple of hours or when the nurse asked. NA-B indicated there was a place to document PRN oxygen administration, O2 saturation levels, and respiratory rate.

During an interview on 9/1/2020, at 3:45 p.m. R4's hospice registered nurse case manager (HCM) confirmed R4 was a hospice patient, confirmed the facility did not have a copy of the hospice care plan, the hospice care plan included respiratory focus, was not aware the facility care plan did not include a respiratory focus, and hospice staff did not document in the facility medical record because they did not have access. HCM confirmed she was notified of R4's respiratory status on 7/31/2020, however since then had not been notified of any respiratory concerns and/or declines. HCM stated during her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 12	F 695		

visit on 8/28/20, she had been sitting next to R4 and could hear adventitious lung sounds without auscultation; since R4 had a history of aspiration pneumonia she prescribed the antibiotic. HCM stated R4 did have fluctuating oxygen saturation levels, had found the ear meter was more accurate, had provided education and directed facility staff to use ear meter, and expected staff to routinely complete full respiratory assessments that included: respiratory rate, lung sounds, and SP02 and notify hospice if there was any changes.

During an interview on 9/3/2020, at 1:13 p.m. director of nursing (DON) stated R4's oxygen was as needed. DON indicated a respiratory assessment was to be completed prior to the administration and prior to removal. DON stated a full assessment included, auscultating lungs, Sp02, respiratory rate, and capillary refill and expected the assessment be documented in the record. DON stated if a resident was on an antibiotic for a respiratory illness a complete respiratory assessment needed to be completed to determine effectiveness.

The facility's 10/2010 policy Oxygen Administration, included:
Preparation: 1) Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2) Review the resident's care plan to assess for any special needs of the resident. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy assess the following. 1) signs or symptoms of cyanosis 2) signs or symptoms of hypoxia 3) signs or symptoms of oxygen toxicity (tracheal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 13	F 695		

irritation, difficulty breathing or slow shallow rate of breathing). 4) vital signs. 5) lung sounds. The Policy indicated documentation should be recorded in the medical record which included: 1. The date and time that procedure was performed, 3. The rate of oxygen flow, route, and rationale. 4) Frequency and duration of treatment. 5. The reason for PRN administration. 6)All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure.

The facility 10/2010 policy Pulse Oximetry (Assessing Oxygen Saturations) included the following:
Assessment:
1. Assess the resident for signs and symptoms of impaired oxygen saturation: a) Altered respirations, difficulty breathing, abnormal breath sounds. b) Cyanotic appearance of nail beds, lips, skin, mucous membranes, skin:
c) Restlessness,irritability and/or d) Confusion, loss of consciousness.
2. Assess the site most appropriate probe placement. a) If a resident has impaired peripheral circulation or hand tremors, place the probe on the ear or bridge of the nose.
11. If SpO2 is less than 90%: a) Reposition the probe and re-evaluate readings. b) If Sp02 is less than acceptable level for resident's condition, notify the physician.
Documentation: The flow sheet should be placed in the medical record. In addition the following information should be recorded in the resident's medical record:
1. The date and time that the procedure was performed
2. The type of probe and location of placement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 14 3. The assessment data gathered prior to the procedure 4. The resident's response to the procedure 5. Any unusual findings and action taken 6. If the resident refused the procedure, the reason why and the interventions taken	F 695		
F 713 SS=D	Physician for Emergency Care Available 24 hrs CFR(s): 483.30(d) §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the on-call physician responded to phone calls for a change of condition for 1 of 1 resident (R19) reviewed for injury of unknown origin. Findings include: R19's admission record indicated R19 had diagnoses of unspecified dementia without behavioral disturbance and age related osteoporosis. R19's quarterly Minimum Data Set dated 6/23/20 indicated R19 had severe cognitive impairment and required extensive assist of one staff for bed mobility, transferring, dressing and toileting. R19's progress notes were reviewed and revealed the following: -8/8/20 "Note Text: Aides stated that the resident	F 713	Corrective Action Facility reached out to Mayo Clinic Health Systems Operations Manager and Senior Services Operations Manager to collaborate on an updated process to ensure 24/7 physician emergency care services are available for the facility. Communication was started on 9/28/2020 with a follow up email sent on 10/2/2020. The facility will continue to collaborate with Mayo Clinic. Corrective Action as it applies to all residents: Facility has clarified the Facility process for reaching on-call physicians which includes the Emergency Department physicians at Austin Mayo Clinic Health System. Process and timeline education will be provided to nursing staff on	10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 15 seemed weaker than normal. They stated that it took them 3 people to get her on the toilet. Will leave a message for NM [nurse manager] to see if she can be reevaluated. Resident does not seem to be weak when sitting in the chair and the resident is alert and oriented x3." -8/9/20 "Note Text: Aides stated that the resident has had increased weakness and it is harder to get her to transfer. When nurse went in to do the dressing change the resident yelled out in pain. She stated that she was having pain in her upper left thigh. Resident did not have any new bruises on her leg and the leg was not red or warm. Resident had difficulty lifting up that leg without her being in pain. Resident was saying the pain was a 7/10. Resident did refuse to go to the hospital if the doctor recommended. Resident was given Tylenol and an ice pack for the pain. The resident did say that the ice pack did help. NM [nurse manager] was called and informed of the situation. She stated that a risk management does not need to be filled out at this time. On call doctor was called but are waiting to hear back." -8/9/20 "Note Text: Resident does have a new skin tear in the back of her left thigh. Measurements are done and a new skin assessment was complete. Wound was covered using standing house orders." -8/10/20 "Note Text: Increased pain in left leg and weakness discussed with [Nurse Practitioner (NP)-A]. Increase Tylenol to 1000 mg TID [three times daily] and PT/OT [physical therapy and occupational therapy] evaluation ordered.	F 713	10/7/2020. Date of Completion: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will include review of on call physician responses received by nursing staff and timeliness of response. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 16	F 713		

-8/11/20 "Note Text: Resident has been sitting comfortably in her chair. Resident denied complaining of any pain in her leg. Resident was transferred using a hoyer and stated having some pain with transfer."

-8/14/20 "Note Text: DON [director of nursing] notified of resident increased pain and decreased ROM to LLE. Staff reporting resident c/o of pain since 8/8 with steady decline in ability to move extremity. No recent fall or known injury noted. Provider evaluation via telehealth 8/14. Provider suspects knee effusion. X-ray {sik} of extremity ordered, naproxen 220 mg BID [twice daily] for 5 days, cold compress to L [left] knee for 20 minutes TID [three time daily] for 5 days. Orders processed, family notified."

-8/15/20 "Note Text: Received x-ray results via fax: (1) left femur shows osteopenia; degenerative change; no fx; no dislocation, and there is moderate joint effusion of the left knee; (2) left knee findings suspicious for impaction of type fx [fracture] lateral tibial {sik} plateau. CT [cat scan] is recommended for further evaluation-- osteopenia; degenerative change; and moderate joint effusion. Results sent to DON."

R19's CT knee left without IV Contrast reported read 8/17/20 included, "Impression: 1. Medial and lateral tibial plateau fractures with some impaction, comminution, and displacement of the lateral tibial plateau fracture. 2. Tricompartmental osteoarthritis in the left knee which is most marked in the lateral patellofemoral joint."

During an interview on 9/3/2020, at 1:02 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 17	F 713		

licensed practical nurse (LPN)-A stated she was the one who wrote the progress note on 8-8-20. LPN-A stated that day the aides told me R19 was more difficult to transfer, she seemed more weak and that was new. LPN-A stated she checked her pain scale; she was not complaining of any pain and had no signs or symptoms of no verbal pain. LPN-A stated she wrote a progress note, notified nurse manager and stated the nurse manager no longer worked here. LPN-A stated she also informed the oncoming nurse there was a change with R19 and informed the aides. LPN-A stated to her knowledge she does not think anyone assessed R19. LPN-A stated she was not sure, if the nurse after her completed an assessment or if nurse manager had completed an assessment. LPN-A stated it was a change of condition for R19 to need three people to help her. LPN-A stated she reported to the nurse manger that R19 had increased weakness, needed three people to transfer and was not complaining of any pain at that time. LPN-A stated she was the nurse on when the R19 started to really show symptoms of pain in that leg. LPN-A stated it was in the morning around 6:30 a.m. and she went to go do her dressing changes on her legs and normally R19 could lift up her legs while she wrapped them to do the dressings. LPN-A stated at this point R19 could not lift her leg and was yelling out in pain, which was very abnormal for her. LPN-A stated she asked R19 where her pain was located and she pointed to her left thigh. LPN-A stated gave her a pain scale using the non-numerical number scale and called the nurse manager that was on call. LPN-A stated she called her and informed her what was going on with the pain and not being able to lift up her leg. LPN-A stated the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 18	F 713		

manger informed me to call the on call doctor and stated she placed an ice pack on her thigh, as that was where she indicated the pain was. LPN-A stated she called the on call doctor twice and never received a call back. LPN-A stated she told the aide to keep R19 in bed for now and to reposition her every two hours. LPN-A stated no communication from the on call provider as no one would call her back and she tried two times to get into contact. LPN-A stated she alerted the nurse manager that was on call that she was not getting a call back from the provider. LPN-A stated the nurse manger stated to continue with the Tylenol, the icing and it would be discussed with the nurse practitioner right away on Monday (the next morning). LPN-A stated the pain was new for R19 on 8/9/20.

During an interview on 9/3/20, at 2:07 p.m. NP-A stated she was first made aware of the weakness and pain in her leg on 8/10/20. NP-A stated she did not take call on the weekend, they (nursing staff) would need to call the on call on the weekends. NP-A stated she did not receive a report of a fall or injury just increased pain or weakness, which sounded to her without seeing her like a physical therapy kind of thing. NP-A stated she did not see anything in the epic [hospital records] record that the facility contacted her regarding R19's pain after the 10th.

During an interview on 9/3/2020, at 2:40 p.m. nursing assistant (NA)-A stated she had gotten R19 up to walk across the room because she was on a walk program to and from the bathroom and stated she was really weak that day and had no reports of pain. NA-A stated she reported it to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 19	F 713		

her nurse. NA-A stated later in that day it took three to get R19 on the commode. NA-A stated R19 still had no complaints of pain, she just was not standing well. NA-A stated the very next day she had her again and once again, she tried to get R19 up to walk her, R19 was dragging her foot and NA-A stated she stopped walking her and sat her back down. NA-A stated R19 still had no complaints of pain. NA-A stated she reported it (the resident's change) to her nurse right away. NA-A stated R19 had no complaints of pain. NA-A stated If you asked R19 is she was having pain she would tell you no. NA-A stated she was off the following few days and when she came back from being off, R19 was in bed and she heard R19 had a broken leg.

During an interview on 9/3/20, at 3:34 p.m. registered nurse (RN)-A stated the licensed practical nurse (LPN) had called her to discuss change in R19's status. RN-A stated the LPN reported R19 had 10 out of 10 pain, when touching her lower extremity, had an excruciating amount of pain, was yelling out in pain and was unable to bear weight in that lower extremity. RN-A stated this was the Sunday of that week. RN-A stated she had advised the nurse to not have her stand on that leg and to use the Hoyer lift with an assist of two, to contact the on call provider with regard if she should be seen, what to do for pain management and to check to see if they would like imaging performed. RN-A stated she also asked the nurse of any known deformities, any redness swelling and all was reported negative. RN-A stated there was no visual deformity such as shortening or internally rotation. RN-A stated the LPN called me again that afternoon and she was still having pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 20	F 713		

transfers were going better with the Hoyer lift and RN-A stated she advised the LPN to call the on call providers back again informing them this was an acute change and we would like them to call us back. RN-A stated the niece was notified did not want her to go to the hospital if possible. RN-A stated the LPN reported again the on call provider never called her back and RN-A told the LPN to please pass on to the next shift to contact RN-A if the provider called and RN-A stated she told the LPN she would have the provider address tomorrow if did not receive a call back. RN-A stated the LPN informed her R19 was ok when in bed and only had pain when she moved. RN-A stated the evening nurse called her that evening and stated he tried twice to get a hold of the on call doctor too and they never called back. RN-A stated she reported it off to director of nursing who was acting as the nurse manager for R19's wing. RN-A stated it was discussed right away at the IDT (interdisciplinary) team meeting at 9:00 a.m. and the nurse practitioner was notified. RN-A stated she had also asked if R19 had any known falls or near miss falls and nothing was noted. RN-A stated she instructed the nurse to put in a progress note regarding the change to the resident and stated she would have expected them to put in a detailed progress note. RN-A stated the LPN did do an assessment of range of motion (ROM) and stated she told her not to continue as the resident was screaming out and that was another reason she told them to use the Hoyer lift and to be very persistent in trying to call the on call providers. RN-A stated she also advised on non pharmalogical measures, PRN (as needed) medications and ice for comfort repositioning to keep her as comfortable as we could until we got

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 21	F 713		

a response. RN-A stated she asked if R19 was able to bend her knee, bear weight and the LPN said no and that was also why she advised them to discontinue the ROM assessment. RN-A stated staff addressed with family to have R19 sent in and family declined. RN-A stated she guided the nurse to do the assessment and she had text messages (of their conversation). RN-A stated the nurses were in constant communication with her throughout the day and they did a very good job.

During an interview on 9/3/20, at 4:21 p.m. the director of nursing (DON) stated she thought that severe pain and change of ROM started on 8-14-20. The DON stated there was nothing shared at the IDT meeting on Monday (about severe pain and change of ROM). The DON stated she was not aware of severe pain or change in ROM until the physical therapy assistant came and told her therapy tried to see R19 and she would not get out of bed. The DON stated that was when they started telling she was having all this pain. The stated the nurses are to call the main number and request the on call provider. The DON stated they tend to take the phone number and have them call back as far as night and weeks. The DON stated they do not even ask for patient name or date of birth, nothing to identify the resident. The DON stated we have had at certain times problems with the on call staff responding. The DON stated she has had meetings/discussion with the hospital administration about it (lack of response from on call providers). The DON stated the expectation was to keep calling and keep requesting to speak to an on call provider. The DON stated it would depend on the severity if the facility were to send

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 713	Continued From page 22 the resident in to the emergency room if they did not receive a call back from on call providers. The DON stated she has addressed this with the medical director, talked with the medical director's boss and other hospital administration. The DON stated they do not have enough providers, providers find it not worth their time. The Physician's services policy revised April 2013, did not include information on call providers.	F 713		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 23 the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to,	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 24 providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 25 clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 26 (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure necessary coordination of care for pressure ulcers and respiratory management between the facility and hospice agency for 1 of 1 residents (R4) who was received hospice services reviewed during the survey. Findings include R4's Admission Record dated 9/3/2020, included diagnoses of encounter for palliative care and dementia with behavioral disturbance. R4's quarterly Minimum Data Set (MDS) dated 7/16/2020, indicated R4 received hospice services. The MDS identified that R4 had unclear speech, rarely/never made herself understood, rarely/never had the ability to understand others, and cognitive skills for decision making was severely impaired. The MDS indicated R4 had verbal and physical behaviors but did not have	F 849	Corrective Action R4 deceased on 9/19/20. Corrective Action as it applies to all residents: All nurses were educated on provider and hospice notification. Education was completed on 09/24/20. In-house audit will be completed on all residents who have oxygen orders. Audit to include ensuring that each resident has parameters in place for oxygen usage, each resident has a current care plan that includes appropriate goals & interventions for oxygen utilization and each resident has supplemental documentation in place for oxygen use. Audit to be completed by 10/5/20.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 27 rejection of care behaviors. The MDS further identified that R4 required extensive assistance from two or more staff members for bed mobility and toilet use and was dependent on staff for personal hygiene and transfers. The MDS indicated R4 was frequently incontinent of urine and always incontinent of bowel. At the time of assessment R4 did not have pressure ulcers, and skin treatments included pressure reducing device for chair and bed, turning and repositioning program, and applications of ointments/medications other than to feet. In addition the MDS also indicated R4 did not require oxygen therapy. R4's pressure ulcer/injury Care Area Assessment (CAA) dated 11/12/2020, included resident is at risk for skin breakdown related to limited mobility and incontinence. CAA also identified R4 to be at moderate risk for pressure ulcer formation and R4 had recently been readmitted to hospice related to overall decline of and progression of disease process. R4's last physician visit prior to survey start on 8/31/2020, was a regulatory visit dated 7/7/2020. The visit note indicated the visit was conducted via real-time audio/video technology related to COVID-19 pandemic. The note included, "She [R4] is enrolled in hospice care and I see from the notes she has been enrolled with [name of hospice agency] since October of 2019 due to a decline associated with her dementia." The note indicated R4 was eating fairly well, had been comfortable, closely followed by hospice, and facility staff did not have any concerns. The visit note had no mention of oxygen use.	F 849	In-house audit to be completed on all residents who have pressure ulcers. Audit to include ensuring that each resident has a current care plan that includes appropriate goals & interventions relating to each pressure ulcer noted. Audit to be completed by 10/5/20. Communication was completed with the Hospice Supervisor on 10/2/20 regarding the facility's expectation of receiving hospice documentation in a timely manner. Facility's health unit coordinator will monitor this weekly to ensure compliance. Date of Completion: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will include the following: that each resident on oxygen has an updated plan of care identifying goals and interventions, and oxygen parameters in place; and that each resident with a pressure ulcer has an updated plan of care identifying goals and interventions related to each specific pressure ulcer. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 28 R4's record lacked evidence of a coordinated care plan with the hospice agency. R4's facility care plan lacked a plan of care that included goals and interventions for oxygen usage for respiratory management. R4's care plan also lacked a plan of care that included goals and interventions for pressure ulcer risk and/or identified R4 had pressure ulcers. The care plan included: Hospice: Coordinate care between hospice and facility to meet resident's specific needs (start date 12/18/19). The record lacked delineation of care tasks between the facility and hospice agency as well as a contact person for communication. R4's physician orders included the following: -Oxygen (02) via nasal cannula at 1-4 L/min (liters per minute) as needed for comfort and shortness of breath (start date 10/28/19). -Augmentin suspension reconstituted (antibiotic medication) 400/57 mg/ml (milligram/milliliter); give 6 ml by mouth three times a day for aspiration pneumonia (start date 8/28/2020) -Left Heel: Apply heel foam dressing then wrap with kerlix (gauze wrap dressing) daily in the evening. Notify hospice if area starts to break down more or any other concerns (start date 8/25/2020) -Right Heel wound stage 2: cleanse wound with wound cleanser, apply foam dressing daily and PRN (as needed) if soiled. Hospice to perform wound care weekly on Fridays. Notify hospice of any signs/symptoms of infection and/or other concerns (start date 8/25/2020) -Bilateral heel protectors on at all times (start date 8/25/2020)	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 29 R4's Skin assessment dated 8/23/2020, indicated R4 had a blister and pressure sore; areas were first observation. 1. Right heel: broken skin and blister to heel, on inner edge, no drainage noted. 6.0 cm (centimeters) x 3.5 cm x 0.2 cm 2. Left heel: Pressure area on heel; on inner edge. 2.0 cm x 3 cm superficial. The assessment indicated R4 did not have signs or symptoms of pain and bilateral lower extremities off loaded to avoid pressure with repositioning. Ongoing. Continue with care plan and off load pressure every two hours or as necessary when redness/blanching noted. Continue to monitor. The assessment did not identify a wound dressing treatment, nor analysis of causal factors. R4's oxygen saturation record reviewed from 7/14/2020 to 9/3/2020 was cross referenced with progress notes, treatment administration record, and respiratory rate documentation. The 02 saturation (PS02) record identified documented saturations below 90%; the record lacked evidence of consistent completed respiratory assessments, implementation of interventions to correct R4's 02 levels when they were low. In addition the record did not identify the amount of oxygen delivered when it was used. Examples included: -7/21/2020, at 3:28 p.m.-PS02 85% oxygen via nasal cannula (amount of oxygen was not identified). The record indicated PS02 was rechecked more than 2 hours later at 5:40 p.m.; PSO2 at that time was 95% on room air. -R4's corresponding progress note dated 7/21/2020, at 3:00 p.m. included: "Author did v/s [vital sign] check with concerns for decline in	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 30 health status. O2Sats are 83, 73, 81, 85, 69, fluctuating ongoing. Cont. to monitor". The record lacked evidence hospice and/or physician was notified and lacked documentation of monitoring. -7/22/2020, PS02 88% on room air -7/23/2020, PS02 88% on room air -7/29/2020, at 10:08 a.m. PS02 85% on room air, at 7:58 p.m. PS02 was 89% on room air. -7/31/2020, at 9:57 a.m. PS02 83% on room air. At 4:43 p.m. PS02 was 98% on oxygen visa nasal cannula (amount of oxygen was not identified) -R4's corresponding progress note dated 7/31/2020 at 10:31 a.m. included "Spoke to hospice regarding continued perfusion in the mid to upper 80's. Informed them we are titrating 02 up to maintain the mid to low 90's. No PRN Ativan given a this time to be contributing to the resp [respiratory] depression. Hospice nurse requesting that a return phone call be made to her if her 02 levels do not get to optimal levels. Call with any further concerns." -8/8/2020, PS02 89% on room air -8/26/2020, PS02 88% on room air R4's record lacked evidence of physician and hospice notification after the wounds were identified. In addition R4's record lacked evidence of hospice assessments and visit notes. Furthermore R4's record lacked evidence of hospice assessments and visit notes pertaining to the respiratory status in regards to oxygen management and aspiration pneumonia. During an observation on 9/1/2020, at 9:00 a.m. R4 sat in her wheelchair without oxygen on; the tubing was observed on the floor next to the wheelchair with the concentrator on. R4's	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 31 respirations were easy and not labored. At 9:02 a.m. an unidentified nursing assistant reapplied the nasal cannula without checking PS02 or notifying the nurse for assessment. -At 9:27 a.m. licensed practical nurse (LPN)-B entered the room. LPN-B verified the presence of the wound in R4's coccyx and indicated it was new. LPN-B measured the coccyx wound: 0.7 mm x 0.2 mm with depth <0.1 mm. LPN-B stated it was out of his scope of practice to stage pressure ulcers, however stated was indicative of a stage II pressure ulcer. LPN-B stated he would reference the facility's standing orders for wound treatments, notify the physician, and document the evaluation. LPN-B asked R4 if she was in pain. -At 10:37 a.m. LPN-B stated it was the charge nurse's responsibility to complete the wound assessments and do the weekly skin assessments, however the facility did not currently have a charge nurse for that unit and the director of nursing was doing wound rounds. LPN-B entered R4's room, appropriately assessed R4's pain level and indicated he pain rating had decreased. LPN-B donned gloves, removed right heel dressing, and measured the open wound which was 2.1 cm x 1.6 cm x <0.1 mm. LPN-B removed gloves, sanitized hands and completed he dressing change per physician orders with no infection control concerns. LPN- donned gloves and removed the left heel dressing; R4's heel was pink, LPN-B palpated heel and reported the entire heel was "boggy". On the left lower heel there was 2 pin red/brown discolorations and red/brown line that measured .5 mm by 0.1 mm. R4 remained relaxed with	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 32 eyes closed and did not display facial grimaces. LPN-B appropriately performed hand hygiene and applied treatment per physician order. LPN-B applied the heel protectors and placed a pillow underneath R4's legs however, R4's heels remained on the bed. LPN-B was informed by surveyor R4's heels were on the bed; LPN-B then adjusted the pillow so that R4's heels were not touching the mattress During an interview on 9/1/2020, at 3:45 p.m. R4's hospice registered nurse case manager (HCM) confirmed R4 was a hospice patient, confirmed the facility did not have a copy of the hospice care plan, the hospice care plan included respiratory focus, was not aware the facility care plan did not include a respiratory focus, and hospice staff did not document in the facility medical record because they did not have access. HCM stated she was on vacation on 7/21/2020, and was not aware if the facility had communicated the low oxygen saturations. HCM confirmed she was notified of R4's respiratory status on 7/31/2020, however since then had not been notified of any respiratory concerns and/or declines. HCM stated during her visit on 8/28/20, she had been sitting next to R4 and could hear adventitious lung sounds without auscultation; since R4 had a history of aspiration pneumonia she prescribed the antibiotic. HCM stated R4 did have fluctuating oxygen saturation levels, had found the ear meter was more accurate, had provided education and directed facility staff to use ear meter, and expected staff to routinely complete full respiratory assessments that included: respiratory rate, lung sounds, and SP02 and notify hospice if there was any changes. HCM stated she was not notified by the facility of	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 33	F 849		

the pressure areas on 8/23/2020. HCM stated she became aware only after the hospice aide called and reported the wounds to her. HCM stated the expectation was the facility notify hospice with the change in skin integrity so that the care plan could be revised and appropriate treatments were ordered and implemented. HCM stated she ordered the dressing changes for the wounds and for heel protectors. HCM stated she assessed the wounds on 8/28/2020 during her routine visit. HCM stated on 8/28/2020, the right heel measured 2.0 cm x 1.5 cm and was a stage 2 pressure ulcer and the bottom of the back of her heel was pink and "spongy" or soft. HCM confirmed R4's facility record did not have copies and/or documentation of wound assessment or a copy of the hospice care plan. HCM stated she did not complete an analysis of causal factors and there had not been discussion with facility interdisciplinary team about causal factors. HCM stated an unawareness the documentation of the weekly skin assessments by licensed nurses was not evident in the medical record; stated had the overall skin inspections been completed the area of breakdown could have been identified earlier and potentially prevented further deterioration.

During an interview on 9/3/2020, at 1:13 p.m. director of nursing (DON) stated staff are supposed to be notifying hospice with any changes in condition and documenting in the record; stated the facility was working on granting access for hospice staff to document in the electronic health record. DON verified R4's record lacked evidence of documentation of care provided by the hospice and R4's record did not have any recent medical records from agency. DON stated R4's facility record should have 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 09/03/2020

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 849	Continued From page 34 hospice care plan and visit notes. The Hospice Agency agreement dated 4/29/2019, included the following: 3.2 Services to be Provided: Facility will provide the services necessary to meet the Hospice Patient's personal care and nursing needs in coordination with the Hospice representative and will ensure the level of care provided is appropriately based on the Hospice Patient's needs. 3.3 Designation of an Interdisciplinary Group Member: Facility will designate a member of the Facility's interdisciplinary group who is responsible to work with hospice staff to coordinate care provided to the hospice patient. The IDG member is responsible for the following: 3.3.1 Collaborating with Hospice representatives and coordinating facility staff participation in the care planning process... this includes how communication will be documented between hospice and facility. 3.3.2 Communicating with hospice representatives and other healthcare providers in the provision of care for patient's terminal illness,...3.3.3 Ensuring the facility communicates with the hospice medical director, the patients attending physician and other practitioners participating in the provision of care to the patient needed..3.3.4 Obtaining the following information from the hospice: a) most recent hospice care plan 3.4 Plan of Care: Hospice will collaborate with facility on a coordinated plan of care developed jointly between hospice and facility. 3.5 Medical Record: Documentation of care and services provided by hospice will be filed an maintained in the facility chart. 3.12 Notification to Hospice Facility will	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 09/03/2020

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 849	Continued From page 35 immediately notify hospice if- 3.12.1 A significant change in physical, mental, or emotional status. 3.12.2 Clinical complications that suggest a need to alter care plan	F 849		

Electronically delivered
September 25, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 1CJ611

Dear Administrator:

The above facility was surveyed on August 31, 2020 through September 3, 2020 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, Unit Supervisor
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: 507-206-2727

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

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

Please feel free to call me with any questions.

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 09/03/2020

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On dates 8/31/2020 thru 9/3/2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found NOT in compliance with the MN State Licensure. The following complaints were investigated,	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 000	Continued From page 1 findings were as followed: H5369093C was substantiated with no deficiencies H5369095C was substantiated with no deficiencies H5369096C was substantiated with a deficiency at F656 H5369094C was substantiated with a defiency at F695, F849 The following complaints were NOT substantiated: H5369097C was not substantiated, however an associated deficiency was identified and issued at F713 H5369092C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to consistently assess, monitor, and evaluate oxygen therapy and failed to monitor and evaluate effectiveness of antibiotic prescribed for respiratory illness for 1 of 3 residents (R4) reviewed for oxygen therapy.	2 270	Corrective Action R4 oxygen order was changed on 09/4/20 to clarify oxygen orders and add parameters. R4 deceased on 09/19/20.	10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 2 Findings include During an interview on 8/31/2020, at 10:58 a.m. RN-B indicated R4's oxygen usage was not being monitored or administered appropriately. RN-B stated a couple of weeks ago a trained medication assistant (TMA) removed R4's oxygen without a licensed nurse completing an assessment to determine if the oxygen could be removed. RN-B stated R4's oxygen saturations (Sp02) were below 90% when she checked (could not remember the exact value), RN-B stated she provided education to the TMA and reapplied the oxygen. RN-B stated an hour and ten minutes later when she had gone back into the room to check on R4, the TMA had again removed the oxygen without first notifying her to complete a respiratory assessment to ensure oxygen could be safely removed, R4's oxygen saturation at that time was 85%. RN-B stated she completed an assessment to determine what may have caused the decrease, notified hospice nurse, and documented the episode. RN-B stated the finger pulse oximeter doesn't always work appropriately; more accurate readings were obtained from the ear meter. RN-B indicated she didn't think that was on the care plan. R4's Admission Record dated 9/3/2020, included diagnoses of palliative care encounter, dysphagia, dementia with behavioral disturbance, and dependence on supplemental oxygen. R4's quarterly Minimum Data Set (MDS) dated 7/16/2020, identified R4's decision making capacity for tasks of daily life was severely impaired and did not have rejection of care behaviors. The MDS indicated R4 required	2 270	Corrective Action as it applies to all residents: All CNA / TMA were educated on nursing scopes of practice and oxygen usage. Education was completed on 9/10/20. All nurses were educated on nursing scopes of practice, oxygen usage and notifications to providers and hospice. Education was completed on 09/24/20. In-house audit was completed on all residents who have oxygen orders. Audit included ensuring that each resident has parameters in place for oxygen usage, each resident has a current care plan that includes appropriate goals & interventions for oxygen utilization and each resident has supplemental documentation in place for oxygen use. Audit was completed on 10/5/20. Communication was completed with the Hospice Supervisor on 10/2/20 regarding the facility's expectation of receiving hospice documentation in a timely manner. Facility's health unit coordinator will monitor this weekly to ensure compliance. Date of Completion: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will ensure that each resident on oxygen has an updated plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 3 extensive assistance from two or more staff for bed mobility, toilet use, and personal hygiene. The MDS indicated R4 did not require oxygen therapy. R4's physician orders included the following: -Augmentin suspension reconstituted (antibiotic medication) 400/57 mg/ml (milligram/milliliter); give 6 ml by mouth three times a day for aspiration pneumonia (start date 8/28/2020) -Oxygen (02) via nasal cannula at 1-4 L/min (liters per minute) as needed for comfort and shortness of breath (start date 10/28/19). R4's record lacked evidence of a coordinated care plan with the hospice agency. R4's facility care plan lacked a plan of care that included goals and interventions for oxygen usage for respiratory management. However, the care plan dated 3/19/2020 did identify R4 was at risk for COVID-19 infection which included the following interventions that directed the following: -Frequent monitoring and documentation of for signs and symptoms of respiratory infection. Indicated if upon evaluation there was new cough, abnormal lung sounds, or shortness of breath immediate physician notification was warranted. -Report symptoms of suspected respiratory infection to physician, infection preventionist, resident, and resident representative. During an observation on 8/31/2020, at 4:00 p.m. R4 sat in her wheelchair in her doorway with oxygen on via nasal cannula; flow rate was 2L/min. R4's nasal cannula was not placed all the way into her nares; R4's breathing was easy and not labored.	2 270	of care identifying goals and interventions, and oxygen parameters in place. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 4 During an observation on 9/1/2020, at 9:00 a.m. R4 sat in her wheelchair without oxygen on; the tubing was observed on the floor next to the wheelchair with the concentrator on 2L/min. R4's respirations were easy and not labored. At 9:02 a.m. an unidentified nursing assistant reapplied the nasal cannula without checking Sp02 or notifying the nurse for assessment. Physician visit dated 7/7/2020, included "no vitals taken during this visit" and had no mention of oxygen usage. R4's medication administration record (MAR) identified the order for PRN (as needed) oxygen, however the MAR did not identify that R4 required oxygen administration. R4's treatment administration record (TAR) included order to "Screen for any difficulty breathing, shortness of breath, cough, sore throat, persistent pain or pressure in the chest, and fever. Note any additional symptoms of chills, muscle pain, sore throat, new loss of taste or smell, GI symptoms every shift for COVID-19 screening indicate 'Yes' if any symptoms and notify supervisor. The documentation included boxes for documentation of "yes or no", temperature, pulse, and oxygen saturations however, did not include documentation of lung sounds or respiratory rate. R4's oxygen saturation record reviewed from 7/14/2020 to 9/1/2020 was cross referenced with progress notes, treatment administration record, and respiratory rate documentation. The Sp02 record identified documented saturations below 90%; the record lacked evidence of consistent completed respiratory assessments, and	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 5 implementation of interventions to correct R4's 02 levels when they were low. In addition the record did not identify the amount of oxygen delivered when it was used. Examples included: -7/16/2020- Sp02 89% on room air -7/17/2020-Sp02 88% on room air -7/21/2020, at 3:28 p.m.-Sp02 85% oxygen via nasal cannula (amount of oxygen was not identified). The record indicated Sp02 was rechecked more than 2 hours later at 5:40 p.m.; Sp02 at that time was 95% on room air. -R4's corresponding progress note dated 7/21/2020, at 3:00 p.m. included: "Author did v/s [vital sign] check with concerns for decline in health status. O2Sats are 83, 73, 81, 85, 69, fluctuating ongoing. Cont. to monitor". The record lacked evidence hospice and/or physician was notified and lacked documentation of monitoring. -7/22/2020, Sp02 88% on room air -7/23/2020, Sp02 88% on room air -7/29/2020, at 10:08 a.m. Sp02 85% on room air, at 7:58 p.m. Sp02 was 89% on room air. -7/31/2020, at 9:57 a.m. Sp02 83% on room air. At 4:43 p.m. Sp02 was 98% on oxygen visa nasal cannula (amount of oxygen was not identified) -R4's corresponding progress note dated 7/31/2020 at 10:31 a.m. included "Spoke to hospice regarding continued perfusion in the mid to upper 80's. Informed them we are titrating 02 up to maintain the mid to low 90's.. Hospice nurse requesting that a return phone call be made to her if her 02 levels do not get to optimal levels. Call with any further concerns." -8/8/2020, Sp02 89% on room air -8/26/2020, Sp02 88% on room air R4's progress note dated 8/28/2020, indicated R4's power of attorney was notified R4 started antibiotic course of Augmentin for aspiration	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 6 pneumonia. Prior to 8/28/2020 the record did not identify documented signs and/or symptoms of aspiration pneumonia or physician notification. In addition R4's record lacked ongoing assessment for side effects and effectiveness of antibiotic. During an interview on 8/31/2020, at 9:41 p.m. registered nurse (RN)-C indicated R4 required oxygen as needed, stated oxygen was applied to resident's whose Sp02 was below 90% and would apply appropriate level of oxygen based on the respiratory assessment which included lung sounds, respiratory rate, shortness of breath, heart rate, Sp02 levels. RN-C stated an unawareness R4 was on an antibiotic for aspiration pneumonia; stated respiratory assessments needed to be completed to determine effectiveness of antibiotic. During an interview on 9/1/2020, at 9:10 a.m. NA-A stated, "I don't know if she is supposed to have oxygen on all the time, they never really tell us." Nursing assistant (NA)-C stated an unawareness if R4 had to wear oxygen all the time. During an interview on 9/1/2020, at 9:27 a.m. licensed practical nurse (LPN)-B stated R4 was not supposed to have oxygen on all the time, it was as needed and on at night. LPN-B stated an assessment was supposed to be completed prior to putting oxygen on and prior to removing. LPN-B indicated when oxygen saturation were low, oxygen would be applied and would reevaluated for effectiveness. LPN-B verified the physician order did not identify goal range for R4's oxygen saturations. LPN-B stated the antibiotic was prescribed as a prophylactic because R4 had a history of aspiration	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 7	2 270		

pneumonia. LPN-B stated a couple of days ago upon respiratory assessment, R4 had adventitious lung sounds and lungs were really diminished at the bases; LPN-B stated he did not document the assessment in R4's record but documented the information on a communication sheet for shift report. LPN-B stated a full respiratory assessment included lung sounds, respiratory rate, and Sp02; the assessments should be completed every shift and documented in the record.

During an interview on 9/1/2020, at 1:22 p.m. TMA-A stated he would check oxygen saturations prior to administering, stated if saturations were low he would apply 2L of oxygen, "recheck every two hours like the order says" and notify the nurse, then the nurse would complete the assessment.

During an interview on 9/1/2020, at 1:47 p.m. NA-B stated R4 did not use oxygen all the time and it was as needed for shortness of breath; R4 could have 1-4 L and the nurse managers determined a goal range for oxygen saturations. NA-B stated she would take R4's O2 saturations and if they were low would apply 2L of oxygen. NA-B stated she would then go tell the nurse and recheck the 02 levels every couple of hours or when the nurse asked. NA-B indicated there was a place to document PRN oxygen administration, O2 saturation levels, and respiratory rate.

During an interview on 9/1/2020, at 3:45 p.m. R4's hospice registered nurse case manager (HCM) confirmed R4 was a hospice patient, confirmed the facility did not have a copy of the hospice care plan, the hospice care plan included respiratory focus, was not aware the facility care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 8 plan did not include a respiratory focus, and hospice staff did not document in the facility medical record because they did not have access. HCM confirmed she was notified of R4's respiratory status on 7/31/2020, however since then had not been notified of any respiratory concerns and/or declines. HCM stated during her visit on 8/28/20, she had been sitting next to R4 and could hear adventitious lung sounds without auscultation; since R4 had a history of aspiration pneumonia she prescribed the antibiotic. HCM stated R4 did have fluctuating oxygen saturation levels, had found the ear meter was more accurate, had provided education and directed facility staff to use ear meter, and expected staff to routinely complete full respiratory assessments that included: respiratory rate, lung sounds, and SP02 and notify hospice if there was any changes. During an interview on 9/3/2020, at 1:13 p.m. director of nursing (DON) stated R4's oxygen was as needed. DON indicated a respiratory assessment was to be completed prior to the administration and prior to removal. DON stated a full assessment included, auscultating lungs, Sp02, respiratory rate, and capillary refill and expected the assessment be documented in the record. DON stated if a resident was on an antibiotic for a respiratory illness a complete respiratory assessment needed to be completed to determine effectiveness. The facility's 10/2010 policy Oxygen Administration, included: Preparation: 1) Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2) Review the resident's care plan	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 9 to assess for any special needs of the resident. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy assess the following. 1) signs or symptoms of cyanosis 2) signs or symptoms of hypoxia 3) signs or symptoms of oxygen toxicity (tracheal irritation, difficulty breathing or slow shallow rate of breathing). 4) vital signs. 5) lung sounds. The Policy indicated documentation should be recorded in the medical record which included: 1. The date and time that procedure was performed, 3. The rate of oxygen flow, route, and rationale. 4) Frequency and duration of treatment. 5. The reason for PRN administration. 6)All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. The facility 10/2010 policy Pulse Oximetry (Assessing Oxygen Saturations) included the following: Assessment: 1. Assess the resident for signs and symptoms of impaired oxygen saturation: a) Altered respirations, difficulty breathing, abnormal breath sounds. b) Cyanotic appearance of nail beds, lips, skin, mucous membranes, skin: c) Restlessness,irritability and/or d) Confusion, loss of consciousness. 2. Assess the site most appropriate probe placement. a) If a resident has impaired peripheral circulation or hand tremors, place the probe on the ear or bridge of the nose. 11. If SpO2 is less than 90%: a) Reposition the probe and re-evaluate readings. b) If Sp02 is less than acceptable level for resident's condition, notify the physician. Documentation: The flow sheet should be placed in the medical record. In addition the following	2 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 270	Continued From page 10 information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed 2. The type of probe and location of placement 3. The assessment data gathered prior to the procedure 4. The resident's response to the procedure 5. Any unusual findings and action taken 6. If the resident refused the procedure, the reason why and the interventions taken SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation and staff education. The DON or designee, could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 270		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by	2 555		10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 555	Continued From page 11 the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for anticoagulation for 2 of 3 residents (R5 and R6) for anticoagulation management. Findings include: R5's Admission Record dated 9/3/2020, indicated R5 was admitted to the facility on 3/5/2020 with diagnoses that included long term use of anticoagulants and therapeutic drug level monitoring and was discharged from the facility on 4/1/2020. R5's hospital after visit summary (AVS) dated 3/5/2020, included general information/education pertaining to prevention of venous thrombosis prevention, and signs and symptoms of bleeding related to anticoagulant use. The AVS also identified R5's INR (international ratio- lab that measures blood viscosity) goal range was 2.0 to 2.5. R5's admission Minimum Data Set (MDS) dated 3/11/2020, indicated R5 required anticoagulant medications. R5's admission orders included Coumadin (anticoagulant medication) 1.5 milligrams (mg) every day on 3/5, 3/6, 3/7, 3/8 and INR on 3/9/2020.	2 555	Corrective Action R5 discharged the facility on 4/1/20. R6 care plan has been updated to include goals & interventions for anticoagulation management that identified risk for bleeding and goals & interventions for therapy. Action completed on: 9/20/2020 Corrective Action as it applies to all residents: In-house audit was completed on all residents who currently are on anticoagulants. Audit included ensuring that each resident has a current care plan that includes goals & interventions for anticoagulation management. Audit was completed on 9/30/20. All nursing leadership was educated on anticoagulation management on 10/2/20. Anticoagulation management was added to the nurse managers care plan checklist and a separate coumadin order entry checklist was created and implemented on 10/2/20. Date of Compliance: 10/9/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 555	Continued From page 12 R5's care plan dated 3/18/2020 did not identify a plan of care with goals and interventions for anticoagulation management that were outlined in the hospital (AVS). R6's Admission Record dated 9/3/2020, included diagnoses of history of venous thrombosis (blood clot) and long term use of anticoagulants. R6's annual Minimum Data Set (MDS) dated 7/25/2020, indicated R6 did not have cognitive impairment and required anticoagulant medications. R6's physician orders included: Coumadin (anticoagulant medication) 1 milligram (mg) every evening on Monday, Wednesday, and Friday and 2 mg every Tuesday, Thursday, Saturday, and Sunday until 9/23/2020 (order start date 8/28/2020) R6's care plan dated 9/9/2019, indicated R6 had a history deep vein thrombosis (DVT); the care plan identified interventions for blood clots however, did not identity R6's risk for bleeding, goals and interventions for anticoagulation management. The care plan also identified R6 was at high risk for falls. During an observation and interview on 9/2/2020, at 10:15 a.m. R6 sat in her wheelchair in her room. R1 stated she took Coumadin; she was not aware of her last International Ratio (INR), (lab that measures viscosity of blood) and stated she wished staff would communicate that to her. R6 stated she bruised easily. R6 then lifted up her shirt to expose her abdomen which revealed two dime sized light purple bruises; R6 stated they were from insulin injections.	2 555	Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will ensure that each resident on anticoagulants has an updated plan of care identifying goals and interventions. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 555	Continued From page 13 During an interview on 9/3/2020, at 1:13 p.m. director of nursing (DON) indicated awareness of R5 and R6's records and stated there should have been a care plan developed for anticoagulation therapy that identified risk for bleeding, goals and interventions of the therapy. Facility policy Care Planning-Interdisciplinary Team policy dated 9/2013 included: Our facility's Care Planning Team is responsible for the development of an individualized comprehensive care plan for each resident. 1) A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS). Facility policy Care Plans, Comprehensive Person Centered policy dated 2/2020 included: A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person centered care plan will: Include measurable objectives and timeframe's. Describe services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Incorporate identified problems areas. Incorporate risk factors associated with identified problems. reflect treatment goals, timetables and objectives in measurable outcomes. Areas of concern that are identified during the resident assessment will be evaluated for before interventions are added to the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
2 555	Continued From page 14 review and revise policies and procedures related to development of a care plan to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21265	MN Rule 4658.0705 Subp. 2 A MedicalCare&Treatment; Availablity -emergency Subp. 2. Availability of physicians for emergency and advisory care. A. A nursing home must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency, and to act in an advisory capacity. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the on-call physician responded to phone calls for a change of condition for 1 of 1 resident (R19) reviewed for injury of unknown origin. Findings include: R19's admission record indicated R19 had diagnoses of unspecified dementia without behavioral disturbance and age related osteoporosis. R19's quarterly Minimum Data Set dated 6/23/20 indicated R19 had severe cognitive impairment and required extensive assist of one staff for bed mobility, transferring, dressing and toileting.	21265	Corrective Action Facility reached out to Mayo Clinic Health Systems Operations Manager and Senior Services Operations Manager to collaborate on an updated process to ensure 24/7 physician emergency care services are available for the facility. Communication was started on 9/28/2020 with a follow up email sent on 10/2/2020. The facility will continue to collaborate with Mayo Clinic. Corrective Action as it applies to all	10/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 15 R19's progress notes were reviewed and revealed the following: -8/8/20 "Note Text: Aides stated that the resident seemed weaker than normal. They stated that it took them 3 people to get her on the toilet. Will leave a message for NM [nurse manager] to see if she can be reevaluated. Resident does not seem to be weak when sitting in the chair and the resident is alert and oriented x3." -8/9/20 "Note Text: Aides stated that the resident has had increased weakness and it is harder to get her to transfer. When nurse went in to do the dressing change the resident yelled out in pain. She stated that she was having pain in her upper left thigh. Resident did not have any new bruises on her leg and the leg was not red or warm. Resident had difficulty lifting up that leg without her being in pain. Resident was saying the pain was a 7/10. Resident did refuse to go to the hospital if the doctor recommended. Resident was given Tylenol and an ice pack for the pain. The resident did say that the ice pack did help. NM [nurse manager] was called and informed of the situation. She stated that a risk management does not need to be filled out at this time. On call doctor was called but are waiting to hear back." -8/9/20 "Note Text: Resident does have a new skin tear in the back of her left thigh. Measurements are done and a new skin assessment was complete. Wound was covered using standing house orders." -8/10/20 "Note Text: Increased pain in left leg and weakness discussed with [Nurse Practitioner (NP)-A]. Increase Tylenol to 1000 mg TID [three times daily] and PT/OT [physical therapy and occupational therapy] evaluation ordered. -8/11/20 "Note Text: Resident has been sitting comfortably in her chair. Resident denied	21265	residents: Facility has clarified the Facility process for reaching on-call physicians which includes the Emergency Department physicians at Austin Mayo Clinic Health System. Process and timeline education will be provided to nursing staff on 10/7/2020. Date of Completion: 10/9/20 Recurrence will be prevented by: DON or designee will complete weekly audits for 1 month, monthly audits for 3 months. Audits will include review of on call physician responses received by nursing staff and timeliness of response. Results will be shared and discussed with the QAPI committee. Correction will be monitored by: Don or designee ; QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 16	21265		

complaining of any pain in her leg. Resident was transferred using a hoyer and stated having some pain with transfer."
-8/14/20 "Note Text: DON [director of nursing] notified of resident increased pain and decreased ROM to LLE. Staff reporting resident c/o of pain since 8/8 with steady decline in ability to move extremity. No recent fall or known injury noted. Provider evaluation via telehealth 8/14. Provider suspects knee effusion. X-ray {sik} of extremity ordered, naproxen 220 mg BID [twice daily] for 5 days, cold compress to L [left] knee for 20 minutes TID [three time daily] for 5 days. Orders processed, family notified."
-8/15/20 "Note Text: Received x-ray results via fax: (1) left femur shows osteopenia; degenerative change; no fx; no dislocation, and there is moderate joint effusion of the left knee; (2) left knee findings suspicious for impaction of type fx [fracture] lateral tibial {sik} plateau. CT [cat scan] is recommended for further evaluation-- osteopenia; degenerative change; and moderate joint effusion. Results sent to DON."
R19's CT knee left without IV Contrast reported read 8/17/20 included, "Impression: 1. Medial and lateral tibial plateau fractures with some impaction, comminution, and displacement of the lateral tibial plateau fracture. 2. Tricompartmental osteoarthritis in the left knee which is most marked in the lateral patellofemoral joint."
During an interview on 9/3/2020, at 1:02 p.m. licensed practical nurse (LPN)-A stated she was the one who wrote the progress note on 8-8-20. LPN-A stated that day the aides told me R19 was more difficult to transfer, she seemed more weak and that was new. LPN-A stated she checked her pain scale; she was not complaining of any pain and had no signs or symptoms of no verbal pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 17	21265		

LPN-A stated she wrote a progress note, notified nurse manager and stated the nurse manager no longer worked here. LPN-A stated she also informed the oncoming nurse there was a change with R19 and informed the aides. LPN-A stated to her knowledge she does not think anyone assessed R19. LPN-A stated she was not sure, if the nurse after her completed an assessment or if nurse manager had completed an assessment. LPN-A stated it was a change of condition for R19 to need three people to help her. LPN-A stated she reported to the nurse manger that R19 had increased weakness, needed three people to transfer and was not complaining of any pain at that time. LPN-A stated she was the nurse on when the R19 started to really show symptoms of pain in that leg. LPN-A stated it was in the morning around 6:30 a.m. and she went to go do her dressing changes on her legs and normally R19 could lift up her legs while she wrapped them to do the dressings. LPN-A stated at this point R19 could not lift her leg and was yelling out in pain, which was very abnormal for her. LPN-A stated she asked R19 where her pain was located and she pointed to her left thigh. LPN-A stated gave her a pain scale using the non-numerical number scale and called the nurse manager that was on call. LPN-A stated she called her and informed her what was going on with the pain and not being able to lift up her leg. LPN-A stated the nurse manger informed me to call the on call doctor and stated she placed an ice pack on her thigh, as that was where she indicated the pain was. LPN-A stated she called the on call doctor twice and never received a call back. LPN-A stated she told the aide to keep R19 in bed for now and to reposition her every two hours. LPN-A stated no communication from the on call provider as no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 18 one would call her back and she tried two times to get into contact. LPN-A stated she alerted the nurse manager that was on call that she was not getting a call back from the provider. LPN-A stated the nurse manger stated to continue with the Tylenol, the icing and it would be discussed with the nurse practitioner right away on Monday (the next morning). LPN-A stated the pain was new for R19 on 8/9/20. During an interview on 9/3/20, at 2:07 p.m. NP-A stated she was first made aware of the weakness and pain in her leg on 8/10/20. NP-A stated she did not take call on the weekend, they (nursing staff) would need to call the on call on the weekends. NP-A stated she did not receive a report of a fall or injury just increased pain or weakness, which sounded to her without seeing her like a physical therapy kind of thing. NP-A stated she did not see anything in the epic [hospital records] record that the facility contacted her regarding R19's pain after the 10th. During an interview on 9/3/2020, at 2:40 p.m. nursing assistant (NA)-A stated she had gotten R19 up to walk across the room because she was on a walk program to and from the bathroom and stated she was really weak that day and had no reports of pain. NA-A stated she reported it to her nurse. NA-A stated later in that day it took three to get R19 on the commode. NA-A stated R19 still had no complaints of pain, she just was not standing well. NA-A stated the very next day she had her again and once again, she tried to get R19 up to walk her, R19 was dragging her foot and NA-A stated she stopped walking her and sat her back down. NA-A stated R19 still had no complaints of pain. NA-A stated she reported it (the resident's change) to her nurse right away. NA-A stated R19 had no complaints of pain.	21265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 19 NA-A stated If you asked R19 is she was having pain she would tell you no. NA-A stated she was off the following few days and when she came back from being off, R19 was in bed and she heard R19 had a broken leg. During an interview on 9/3/20, at 3:34 p.m. registered nurse (RN)-A stated the licensed practical nurse (LPN) had called her to discuss change in R19's status. RN-A stated the LPN reported R19 had 10 out of 10 pain, when touching her lower extremity, had an excruciating amount of pain, was yelling out in pain and was unable to bear weight in that lower extremity. RN-A stated this was the Sunday of that week. RN-A stated she had advised the nurse to not have her stand on that leg and to use the Hoyer lift with an assist of two, to contact the on call provider with regard if she should be seen, what to do for pain management and to check to see if they would like imaging performed. RN-A stated she also asked the nurse of any known deformities, any redness swelling and all was reported negative. RN-A stated there was no visual deformity such as shortening or internally rotation. RN-A stated the LPN called me again that afternoon and she was still having pain, transfers were going better with the Hoyer lift and RN-A stated she advised the LPN to call the on call providers back again informing them this was an acute change and we would like them to call us back. RN-A stated the niece was notified did not want her to go to the hospital if possible. RN-A stated the LPN reported again the on call provider never called her back and RN-A told the LPN to please pass on to the next shift to contact RN-A if the provider called and RN-A stated she told the LPN she would have the provider address tomorrow if did not receive a call back. RN-A stated the LPN informed her R19	21265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 20	21265		

was ok when in bed and only had pain when she moved. RN-A stated the evening nurse called her that evening and stated he tried twice to get a hold of the on call doctor too and they never called back. RN-A stated she reported it off to director of nursing who was acting as the nurse manager for R19's wing. RN-A stated it was discussed right away at the IDT (interdisciplinary) team meeting at 9:00 a.m. and the nurse practitioner was notified. RN-A stated she had also asked if R19 had any known falls or near miss falls and nothing was noted. RN-A stated she instructed the nurse to put in a progress note regarding the change to the resident and stated she would have expected them to put in a detailed progress note. RN-A stated the LPN did do an assessment of range of motion (ROM) and stated she told her not to continue as the resident was screaming out and that was another reason she told them to use the Hoyer lift and to be very persistent in trying to call the on call providers. RN-A stated she also advised on non pharmalogical measures, PRN (as needed) medications and ice for comfort repositioning to keep her as comfortable as we could until we got a response. RN-A stated she asked if R19 was able to bend her knee, bear weight and the LPN said no and that was also why she advised them to discontinue the ROM assessment. RN-A stated staff addressed with family to have R19 sent in and family declined. RN-A stated she guided the nurse to do the assessment and she had text messages (of their conversation). RN-A stated the nurses were in constant communication with her throughout the day and they did a very good job.

During an interview on 9/3/20, at 4:21 p.m. the director of nursing (DON) stated she thought that severe pain and change of ROM started on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 21 8-14-20. The DON stated there was nothing shared at the IDT meeting on Monday (about severe pain and change of ROM). The DON stated she was not aware of severe pain or change in ROM until the physical therapy assistant came and told her therapy tried to see R19 and she would not get out of bed. The DON stated that was when they started telling she was having all this pain. The stated the nurses are to call the main number and request the on call provider. The DON stated they tend to take the phone number and have them call back as far as night and weeks. The DON stated they do not even ask for patient name or date of birth, nothing to identify the resident. The DON stated we have had at certain times problems with the on call staff responding. The DON stated she has had meetings/discussion with the hospital administration about it (lack of response from on call providers). The DON stated the expectation was to keep calling and keep requesting to speak to an on call provider. The DON stated it would depend on the severity if the facility were to send the resident in to the emergency room if they did not receive a call back from on call providers. The DON stated she has addressed this with the medical director, talked with the medical director's boss and other hospital administration. The DON stated they do not have enough providers, providers find it not worth their time. The Physician's services policy revised April 2013, did not include information on call providers. SUGGESTED METHOD OF CORRECTION: The facility could review agreements with on-call physician in combination with policy and procedures for 24/7 physician services. The facility then could consult with the medical director to either put a system in place to ensure	21265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 09/03/2020

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) COMPLETE DATE
21265	Continued From page 22 calls from the on-call physician are returned timely. The facility could then educate staff members on procedures for contacting the physician and develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21265		