

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered August 5, 2021

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

RE: CCN: 245369

Cycle Start Date: June 3, 2021

### Dear Administrator:

On August 4, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 24, 2021

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

RE: CCN: 245369

Cycle Start Date: March 6, 2021

#### Dear Administrator:

On June 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

### **DEPARTMENT CONTACT**

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 3, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

St Marks Living June 24, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by December 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 07/06/2021 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245369	B. WING _		C 06/03/202	C <b>06/03/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912	1 00/00/202		
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F 000	INITIAL COMMENT	ΓS	F 00	0			
	conducted at your f to be NOT in comp	ard abbreviated survey was acility. Your facility was found liance with the requirements of art B, Requirements for Long s.					
		olaint was found to be H5369112C (MN00066458), red at F686.					
	SUBSTANTIATED: however NO deficie	plaint was found to be H5369111C (MN00073210), encies were cited due to ed by the facility prior to survey.					
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 686 SS=D	onsite revisit of you validate that substa regulations has bee Treatment/Svcs to	Prevent/Heal Pressure Ulcer	F 68	6	8/3/21	I	
	resident, the facility (i) A resident receiv professional standa pressure ulcers and	sure ulcers. orehensive assessment of a		TITLE	(X6) DAT		

Electronically Signed 07/01/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		245369	B. WING			C <b>06/03/2021</b>	
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F 686	demonstrates that it (ii) A resident with professional st promote healing, promote with securately assessed was offered for 1 of pressure ulcers.  Findings include:  R2's Face Sheet profiagnoses of Alzhe with long term use (irregular and often term use of aspiring terms and had two existing (Partial thickness is shallow open ulcer without slough. May open/ruptured seruit R2's care plan print required assistance.	dividual's clinical condition they were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent veloping.  NT is not met as evidenced ation, interview, and document ailed to ensure skin was d and timely repositioning at 3 residents (R2) reviewed for a resident (R2) reviewed for a repositioning at 3 residents (R2) reviewed for a reposition and at a resident at a reposition at a reposition at a set (MDS) 5/26/21, indicated R2 had a impairment, required a required a reposition and bladder, and a resident and bladder, and a set (MDS) further indicated R2 and a reposition and bladder, and stage II pressure ulcers a set of dermis presenting as a with red or pink wound bed, a resident as an intact or a received and bladder, and a set of the resident as an intact or a resident and a reposition and a reposition at a reposition and a reposition at a repo	F 6	How corrective action will be accomplished for those reshave been affected by the correctice? The CNAs for R2 educated on timely reposition and NA-B) R2 did not suffer events since identifying deficient completed and skin breakdown. How widentify other residents having potential to be affected by the deficient practice? Prompts the TAR to alert nursing start assessment is to be completed designed is completing week skin and wound completion residents. All residents curriculties have had a care plar completed. Skin assessment is to be completed skin and wound completion residents. All residents curriculties have had a care plar completed. Skin assessment what me reviewed for compliance with Signage added to bathing a visual to alert to have the nursing added to ensure that the deficient not recur? CNA and nursing educated on 5/10/21, 5/13/2	sidents four deficient deficient deficient deficient deficient deficient practice deficient practice deficient practice deficient practice deficient practice deficient deficien	A-A erse ctice. d on ing bility, cility to kin N or s for the erse challed be made, will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 686	indicated weekly treinclude measuremed breakdown's width, and exudate and an observations.  R2's Braden Scale Risk dated 5/26/21 indicating moderated R2's current physic indicated to offload for at least one hou has pressure applied to R2's Weekly Ulcer/Tool dated 5/26/21, right buttock stage centimeter (cm) by pressure ulcer measuressessment further granulation tissue promation of granulation	cottom. The care plan further eatment documentation was to ent of each area of skin length, depth, type of tissue my other notable changes or for Predicting Pressure Sore included a score of 14, resident by laying down in bed rafter every meal. Resident to coccyx. Ensure no this area.  Complex Wound Observation indicated the resident had a lI pressure ulcer measuring 8 (x) 5 cm; and a left buttock suring 8 cm x 5 cm. The indicated there was resent (beefy red: The ation tissue is thought to be an a the healing process of ds. Wound has to be a Stage ole to have granulation  at weekly Ulcer. Complex to the complex of the dated 5/26/21 for R2, and the dated 5/26	F 686	6/23/21 regarding timely skin assessments, timely repositioning pressure ulcers, immobility, and s breakdown. Signage added to bat areas as a visual to alert to have the nurse complete skin assessment. Prompts placed into the TAR to all nursing staff that a skin assessment be completed. Audits will be condusing an audit tool to review: week assessments complete in compliate policy and residents are reposition timely manner per care plan. How facility will monitor its corrective at ensure that the deficient practice is corrected and will not recur. Reposition audits to be conducted on all shift or designee will review repositionial audits two times per week for one for compliance, weekly skin assess audits, and DON or designee will residents weekly for one month. Education will be provided to specified to specified concerns will be correct immediately, documented education be provided, and audit findings with submitted to the facility's QAPI for monitoring, recommendations, or up. The administrator will be responsible to the substantiating substantial compliance. Dates condition will be completed: August 3 action will b	kin hing he ert ent is to ucted kly skin nce with ned in a the ctions to s being sitioning s: DON ng month audit all effic staff ill be cesses. ed on will I be further follow onsible rective		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	CON	COMPLETED		
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F 686	was conducted. At sitting in a wheelch w/c approximately common area of th a.m., a nursing ass taking R2 in her w/c breakfast. At 8:00 the common area of At 8:20 a.m., R2 wain her w/c in the counit. At 8:35 a.m., (LPN)-A propelled I medication then relarea within two min slumped over to the closed and appeara.m., R2 was taken transferred into her repositioning for 2 I On 6/3/21, at 10:30 in recliner in her roand balloon volleyb common area outs. On 6/3/21, at 12:00 observed toileting. R near the bottom of reddened and exterior to toileting. R near the bottom of reddened and exterior to toileting. R near the bottom of reddened and exterior to toileting. R near the bottom of reddened and exterior to toileting. The right and left but cm x 5 cm on each be open. There we	a.m. a continuous observation 6:36 a.m. R2 was observed air (w/c) and self-propelling 10 feet from her room to the e Golden Oak unit. At 7:25 istant (NA) was observed to the dining room for 3 a.m., R2 was brought back to of the Golden Oak unit by staff. As observed sleeping/napping mmon area of the Golden Oak licensed practical nurse R2 into her room to administer rurned R2 back to the common utes. At 9:03 a.m., R2 was e left side of her w/c with eyes ed to be sleeping. At 9:32 into her room by staff and recliner. R2 was not offered nours and 56 minutes.  I a.m. R2 was observed resting om. There was an exercise all activity occurring in the						

PRINTED: 07/06/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245369	B. WING	WING Of			C <b>06/03/2021</b>	
	PROVIDER OR SUPPLIER			40	TREET ADDRESS, CITY, STATE, ZIP CODE 00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912	007		
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F 686	may have been open with the cream cover. R2's bottom had prup but now was loo NA-B confirmed R2 repositioning sched kiosk would alert the been repositioned at the residents up so ear prefer staff to lay R recliner after breaking the weight stated ideally she will be the recliner after breaking the recliner after breaking the recliner of bed more than the resident of the recliner or bed more than the recliner or bed more than the recliner of his placed in her recline as that was what the relayed to her.  When interviewed the resident of t	hin the reddened area that en but was difficult to assess ering them. NA-B indicated eviously pretty much cleared king worse again. NA-A and was on an every two hour fule and when charting in the em when the resident had last and needed to be repositioned.  On 6/3/21, at 1:36 p.m. family dicated the staff get the flast and before activities, to pattern on her tailbone. FM-A would like to see R2 put into eakfast from 8:00 a.m. to eat her up so she can attend an then lay her down again. I R2 shouldn't be in her e than 2 hours during the day.  On 6/2/21, at 2:11 p.m. NA-B performed R2's morning cares dent up for the day. NA-B was repositioned and er at approximately 9:20 a.m. the other staff on the unit had and for 6/2/21, at 2:29 p.m. the foon) stated her expectation and schedule would be at least standard of care. DON tent should have been expectation and schedule would be at least standard of care. DON tent should have been expectation and schedule would be at least standard of care. DON tent should have been expectation and schedule would be at least standard of care. DON tent should have been expectation and schedule would be at least standard of care. DON tent should have been expectation and schedule would be at least standard of care. DON tent should have been expectation.	F6	686				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	reviewed R2's last of 5/26/21, and confirm had a stage II pressiouttock measuring DON was asked to approximately 2:45 observed with the Ecome off the area a color surrounding the upper right and left reddened skin was there were 2 closed one open macerate measuring 0.8 cm of the the the the the the completed with the assessment and modern pooling. Wound may be upper tight and been idea and would be a professed April 2020, residents with or at individualized schedinterdisciplinary car for repositioning ba factors and current Evaluate, report and in the skin. Review	yound/skin assessment dated med it indicated the resident sure ulcer on the right and left 8 cm x 5 cm on each side; observe R2's bottom. At p.m. R2's bottom was DON. The barrier cream had and now appeared bright red in the sacral/coccyx area and buttock near the coccyx. The intact though within the area of small macerated areas and did area on the left buttock of 0.6 cm. DON confirmed of the bemore education nursing staff related to the easuring of pressure ulcers. Industry during the QAPI meeting that the entified as areas of concernitive moving forward.  Evention of Pressure Injuries, indicated: Reposition all risk of pressure injuries on an andule, as determined by the eteam. Choose a frequency sed on the resident's risk clinical proactive guidelines. In document potential changes of the interventions and iveness on an ongoing basis.	F 6	86		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 24, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: YHXB11

#### Dear Administrator:

The above facility was surveyed on June 3, 2021 through June 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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.

St Marks Living June 24, 2021 Page 2

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:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Flig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 07/06/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00394	B. WING			3/2021
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PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of f	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon				
	result in the assess	ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	your facility by surve Department of Heal found NOT in comp Licensure. Please in of correction you ha	rS: aint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was sliance with the MN State andicate in your electronic planate reviewed these orders and en they will be completed.				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 07/01/21

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00394	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING		H AVENUE S MN 55912	OUTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:	laint was found to be H5369112C (MN00066458) er issued at 4658.0525				
	SUBSTANTIATED:	laint was found to be H5369111C (MN00073210), ing orders were issued.				
	the State Licensing Federal software. T	nent of Health is documenting Correction Orders using ag numbers have been nota state statutes/rules for				
	Nursing Homes. Th appears in the far-le	te assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is				
	listed in the "Summ column and replace	ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes				
	the findings which a statute after the sta	are in violation of the state tement, "This Rule is not met				
		ollowing the surveyor's findings Method of Correction and rrection.				
		participate in the electronic nsure orders consistent with				
	Informational Bullet	in 14-01, available at				
		state.mn.us/facilities/regulatio 1.html The State licensing				
		ed on the attached Minnesota				
		Ith orders being submitted to				
		Although no plan of correction ate Statutes/Rules, please				
		RRECTED" in the box				
	available for text. Yo	ou must then indicate in the				
		ensure process, under the				
		date, the date your orders will electronically submitting to				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00394	B. WING			3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	the Minnesota Depais enrolled in ePOC not required at the I state form.  PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	artment of Health. The facility and therefore a signature is pottom of the first page of RD THE HEADING OF THE	2 900			8/3/21
	positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this tirthe physician has of this MN Requirements. Based on observation review the facility far accurately assesses	g. Hesidents must be body alignment. The position to change their own hours, time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or redered a different interval.  The position of the physician at repositioning and timely repositioning a residents (R2) reviewed for		How corrective action will be accomplished for those residents thave been affected by the deficien practice? The CNAs for R2 were eon timely repositioning. (NA-A and R2 did not suffer any adverse ever identifying deficient practice. CNA	t ducated NA-B) nts since and	
	diagnoses of Alzhei with long term use	inted 6/2/21, indicated mer's disease, type 2 diabetes of insulin, and atrial fibrillation rapid heart rate) with long		nursing staff were educated on 5/1 5/13/21, and 6/23/21 regarding time assessments, timely repositioning, pressure ulcers, immobility, and subreakdown. How will the facility identified other residents having the potential	ely skin kin entify	

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Minneso	ta Department of He	alth			FORM APPRO	JΛFD
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		00394	B. WING		C <b>06/03/202</b> 1	1
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMP	PLETE
2 905	R2's annual Minimulassessment dated a moderate cognitive extensive assistant locomotion on/off upersonal hygiene. Was frequently inco and had two existin (Partial thickness loshallow open ulcer without slough. May open/ruptured seruing R2's care plan print required assistance directed staff to reppressure areas on a indicated weekly trainclude measurement breakdown's width, and exudate and an observations.  R2's Braden Scale Risk dated 5/26/21, indicating moderate R2's current physici indicated to offload for at least one hou has pressure area to pressure applied to R2's Weekly Ulcer/Tool dated 5/26/21, right buttock stage	arm Data Set (MDS) 5/26/21, indicated R2 had impairment, required se with bed mobility, transfer, nit, dressing, toilet use, and The MDS further indicated R2 ntinent of bowel and bladder, g stage II pressure ulcers as of dermis presenting as a with red or pink wound bed, a also present as an intact or m filled blister)  ed 6/2/21, indicated R2 at to turn/reposition, and osition frequently due to cottom. The care plan further eatment documentation was to ent of each area of skin length, depth, type of tissue my other notable changes or  for Predicting Pressure Sore included a score of 14, a risk for pressure ulcers.  fan orders printed 6/2/21, resident by laying down in bed r after every meal. Resident to coccyx. Ensure no	2 905	affected by the same deficient pra Prompts placed into the TAR to almursing staff that a skin assessme be completed. DON or designee is completing weekly audits for skin wound completion on all residents residents currently in the facility had a care plan review completed. Skin assessments will be reviewed for compliance with policy. Signage a bathing areas as a visual to alert to the nurse complete skin assessme What measures will be put into plasystemic changes made, to ensure the deficient practice will not recur and nursing staff were educated of 5/10/21, 5/13/21, and 6/23/21 regatimely skin assessments, timely repositioning, pressure ulcers, immand skin breakdown. Signage additional bathing areas as a visual to alert to the nurse complete skin assessme Prompts placed into the TAR to almursing staff that a skin assessme be completed. Audits will be conducted and using an audit tool to review: week assessments complete in compliance policy and residents are reposition timely manner per care plan. How facility will monitor its corrective accensure that the deficient practice in corrected and will not recur. Report Audits to be conducted on all shift or designee will review repositionic two times per week for one month compliance, weekly skin assessment audits, and DON or designee will residents weekly for one month. Expenditure to the signee will are sidents weekly for one month.	ert ent is to s and . All ave had n  dded to o have ent. ace, or e that ?? CNA arding  mobility, led to o have ent. ert ent is to ucted kly skin nce with led in a the ctions to s being sitioning s: DON ng audits for ent audit all	
		suring 8 cm x 5 cm. The indicated there was		will be provided to specific staff mass needed and audits will be revie		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
					С	
		00394	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
2 905	Continued From pa	ge 4	2 905			
2 905	granulation tissue programation of granulation of granulation of granulation termediate step in full-thickness wound. III, IV, or Unstageal present).  Although the currer Wound Observation indicated the reside ulcers measuring 8 on 6/3/21, the areas reddened area upo and not open. Prior R2 had a history of areas upon buttock. On 6/3/21, at 6:36 a was conducted. At sitting in a wheelch w/c approximately common area of the a.m., a nursing ass taking R2 in her w/c breakfast. At 8:08 the common area of the	present (beefy red: The ation tissue is thought to be an a the healing process of ds. Wound has to be a Stage ole to have granulation  In tweekly Ulcer. Complex and tool dated 5/26/21 for R2, and the 2 stage II pressure cm x 5 cm, upon observation as were observed to be an on each side of the buttock skin documentation indicated if macerated skin with open s.  In a.m. a continuous observation 6:36 a.m. R2 was observed air (w/c) and self-propelling IO feet from her room to the ele Golden Oak unit. At 7:25 istant (NA) was observed to the dining room for 8 a.m., R2 was brought back to of the Golden Oak unit by staff.	2 905	understanding of processes. Ident concerns will be corrected immedi documented education will be provand audit findings will be submitted facility's QAPI for further monitoring recommendations, or follow up. The administrator will be responsible for obtaining and substantiating substantiating and substantiating substantiating compliance. Dates corrective action completed: August 3, 2021	ately, vided, d to the g, ne or antial	
	in her w/c in the cor unit. At 8:35 a.m., I (LPN)-A propelled F	as observed sleeping/napping mmon area of the Golden Oak icensed practical nurse R2 into her room to administer urned R2 back to the common				
	area within two min slumped over to the closed and appeare a.m., R2 was taken transferred into her	utles. At 9:03 a.m., R2 was eleft side of her w/c with eyes ed to be sleeping. At 9:32 into her room by staff and recliner. R2 was not offered nours and 56 minutes.				
		a.m. R2 was observed resting om. There was an exercise				

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AND PLAN OF CORRECTION IDENTIFICATION NOMBER.  A. BUILDING:  C.		
	С	
00394 B. WING 06/03/20	/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ST MARKS LIVING 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
	(X5) COMPLETE DATE	
and balloon volleyball activity occurring in the common area outside of R2's door.  On 6/3/21, at 12:00 p.m. NA-A and NA-B were observed tolleting R2 and lying the resident down after the lunch meal. R2's bottom was observed prior to toileting. R2's sacral/coccyx area (located near the bottom of vertebral spinal column) was reddened and extended to the right and left buttocks; the area had barrier cream on it which lightened the appearance. The reddened area on the right and left buttocks was approximately 8 cm x 5 cm on each side though did not appear to be open. There were also two smaller areas observed (one on the right buttock and one on the left buttock) within the reddened area that may have been open but was difficult to assess with the cream covering them. NA-B indicated R2's bottom had previously pretty much cleared up but now was looking worse again. NA-A and NA-B confirmed R2' was on an every two hour repositioning schedule and when charting in the kiosk would alert them when the resident had last been repositioned and needed to be repositioned.  When interviewed on 6/3/21, at 1:36 p.m. family member (FM)-A indicated the staff get the residents up so early in the morning that she'd prefer staff to lay R2 down or place her in the recilier after breakfast from 8:00 a.m. to 10:00 a.m., then get her up so she can attend an activity, go to lunch, then lay her down again. FM-A further stated R2 shouldn't be in her recliner or bed more than 2 hours during the day.  When interviewed on 6/2/21, at 2:11 p.m. NA-B confirmed she had performed R2's morning cares		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00394	B. WING		06/0	) 3/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ST MARKS LIVING  400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
2 905	and gotten the reside further confirmed R placed in her recline as that was what the relayed to her.  When interviewed of director of nursing (for R2's repositioning every 2 hours as a confirmed the reside offloaded within the should have been last as a confirmed the reside offloaded within the should have gotten reviewed R2's last to 5/26/21, and confirmed the astage II pressibuttock measuring DON was asked to approximately 2:45 observed with the Come off the area acolor surrounding the upper right and left reddened skin was there were 2 closed one open macerate measuring 0.8 cm as there would need to completed with the assessment and med DON further stated morning, wound madulcers had been ideand would be a program of the state of the	ge 6  dent up for the day. NA-B 2 was repositioned and er at approximately 9:20 a.m. e other staff on the unit had  on 6/2/21, at 2:29 p.m. the DON) stated her expectation ng schedule would be at least standard of care. DON ent should have been 2-hour timeframe and also ayed down after breakfast so en up for the activity. DON wound/skin assessment dated med it indicated the resident sure ulcer on the right and left 8 cm x 5 cm on each side; observe R2's bottom. At p.m. R2's bottom was OON. The barrier cream had and now appeared bright red in the sacral/coccyx area and buttock near the coccyx. The intact though within the area I small macerated areas and d area on the left buttock to 0.6 cm. DON confirmed to be more education nursing staff related to the easuring of pressure ulcers. during the QAPI meeting that an agement and pressure tentified as areas of concern tiect moving forward.	2 905					
	revised April 2020, residents with or at	evention of Pressure Injuries, indicated: Reposition all risk of pressure injuries on an fulle, as determined by the						

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A. BUILDING: COMPLETE  O0394  A. BUILDING: COMPLETE  C  06/03/20							
	C						
	06/03/2021						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ST MARKS LIVING 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912							
	CORRECTIVE ACTION SHOULD BE COMPLETE DATE						
2 905  Continued From page 7 interdisciplinary care team. Choose a frequency for repositioning based on the resident's risk factors and current clinical proactive guidelines. Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis.  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policy and procedures for pressure ulcer assessment and delivery of resident care to ensure resident needs are met. The DON could educate staff on policies and procedure and monitor care to ensure implemented. The DON or designee could review findings with facility Quality Assurance Committee.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.							

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