

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.

M. Ping

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:

St Marks Living June 24, 2021 Page 2

- 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

	-	AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES	1			. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245369	B. WING _			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST MAR	<b>KS LIVING</b>			400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
	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.				
		plaint was found to be H5369112C (MN00066458), red at F686.				
	SUBSTANTIATED: however NO deficie	laint was found to be H5369111C (MN00073210), encies were cited due to ed by the facility prior to survey.				
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a 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	36		8/3/21
	resident, the facility (i) A resident receiv professional standa	sure ulcers. prehensive assessment of a				
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically 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 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.

PRINTED: 07/06/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/06/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245369	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	<b>KS LIVING</b>			40	00 - 15TH AVENUE SOUTHWEST		
				Α	USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review the facility fa accurately assesse was offered for 1 of pressure ulcers. Findings include: R2's Face Sheet pr diagnoses of Alzhei with long term use of (irregular and often term use of aspirin. R2's annual Minimu assessment dated a moderate cognitive extensive assistance locomotion on/off up personal hygiene. was frequently inco and had two existin (Partial thickness lo shallow open ulcer without slough. May open/ruptured serue R2's care plan print required assistance	dividual's clinical condition hey 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 tion, interview, and document tiled to ensure skin was d and timely repositioning 3 residents (R2) reviewed for inted 6/2/21, indicated mer's disease, type 2 diabetes of insulin, and atrial fibrillation rapid heart rate) with long m Data Set (MDS) 5/26/21, indicated R2 had impairment, required the MDS further indicated R2 ntinent of bowel and bladder, g stage II pressure ulcers os of dermis presenting as a with red or pink wound bed, y also present as an intact or m filled blister) ed 6/2/21, indicated R2 e to turn/reposition, and	F	\$86	How corrective action will be accomplished for those residents for have been affected by the deficient practice? The CNAs for R2 were educated on timely repositioning. (N and NA-B) R2 did not suffer any ad events since identifying deficient pr CNA and nursing staff were educate 5/10/21, 5/13/21, and 6/23/21 regar timely skin assessments, timely repositioning, pressure ulcers, imm and skin breakdown. How will the fa- identify other residents having the potential to be affected by the same deficient practice? Prompts placed the TAR to alert nursing staff that a assessment is to be completed. DC designee is completing weekly aud skin and wound completion on all residents. All residents currently in facility have had a care plan review completed. Skin assessments will b reviewed for compliance with policy Signage added to bathing areas as visual to alert to have the nurse cor skin assessment. What measures of put into place, or systemic changes to ensure that the deficient practice not recur? CNA and nursing staff w	NA-A verse actice. ed on rding obility, acility e into skin DN or its for the c a mplete will be s made, will	
	shallow open ulcer without slough. May open/ruptured serue R2's care plan print required assistance	with red or pink wound bed, also present as an intact or m filled blister) ed 6/2/21, indicated R2			Signage added to bathing areas as visual to alert to have the nurse cor skin assessment. What measures put into place, or systemic changes to ensure that the deficient practice	a mplete will be made, will	

Facility ID: 00394

If continuation sheet Page 2 of 6

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI		(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(	2
		245369	B. WING _			06/0	03/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ST MAR	KS LIVING				00 - 15TH AVENUE SOUTHWEST USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 686	Continued From pa	age 2	F 68	36			
		bottom. The care plan further			6/23/21 regarding timely skin		
	indicated weekly tre	eatment documentation was to			assessments, timely repositioning,		
		ent of each area of skin			pressure ulcers, immobility, and sk		
		length, depth, type of tissue			breakdown. Signage added to bath		
	and exudate and a observations.			areas as a visual to alert to have th	e		
	observations.				nurse complete skin assessment. Prompts placed into the TAR to ale	rt	
	R2's Braden Scale	for Predicting Pressure Sore			nursing staff that a skin assessmer		
		, included a score of 14,			be completed. Audits will be condu		
		e risk for pressure ulcers.			using an audit tool to review: weekl		
					assessments complete in compliar		
		R2's current physician orders printed 6/2/21, indicated to offload resident by laying down in bed			policy and residents are repositione		
				timely manner per care plan. How t facility will monitor its corrective act			
		Ir after every meal. Resident to coccyx. Ensure no			ensure that the deficient practice is		
	pressure applied to				corrected and will not recur. Repos	itioning	
					Audits to be conducted on all shifts		
		Complex Wound Observation			or designee will review repositionin audits two times per week for one r		
		Il pressure ulcer measuring 8			for compliance, weekly skin assess		
		(x) 5 cm; and a left buttock			audits, and DON or designee will a		
		asuring 8 cm x 5 cm. The			residents weekly for one month.		
		r indicated there was			Education will be provided to speci		
		present (beefy red: The			members as needed and audits wil		
	0	ation tissue is thought to be an n the healing process of			reviewed for understanding of proc Identified concerns will be corrected		
		ids. Wound has to be a Stage			immediately, documented educatio		
		ble to have granulation			be provided, and audit findings will		
	present).	5			submitted to the facility's QAPI for t		
					monitoring, recommendations, or for		
		nt weekly Ulcer. Complex			up. The administrator will be respon	nsible	
		n tool dated 5/26/21 for R2, ent had 2 stage II pressure			for obtaining and substantiating substantial compliance. Dates corre	ective	
		cm x 5 cm, upon observation			action will be completed: August 3,		
		s were observed to be				'	
		on on each side of the buttock					
	and not open. Prior	skin documentation indicated					
	R2 had a history o areas upon buttock	f macerated skin with open					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
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		245369	B. WING				C 0 <b>3/2021</b>	
NAME OF I	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ST MAR	KS LIVING				00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	SHOULD BE COMPLÉTIC		
F 686	Continued From pa	ge 3	F 6	86				
	was conducted. At a sitting in a wheelchain w/c approximately from common area of the a.m., a nursing assistaking R2 in her w/c breakfast. At 8:08 the common area of the common area of At 8:20 a.m., R2 was in her w/c in the corrunit. At 8:35 a.m., I (LPN)-A propelled F medication then ret area within two min slumped over to the closed and appeare a.m., R2 was taken transferred into her repositioning for 2 the Con 6/3/21, at 10:30 in recliner in her rot and balloon volleyb common area outsite. On 6/3/21, at 12:00 observed toileting. R2 near the bottom of reddened and exter buttocks; the area the lightened the appear 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 a Golden Oak unit. At 7:25 istant (NA) was observed to the dining room for a.m., R2 was brought back to if the Golden Oak unit by staff. 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 utes. At 9:03 a.m., R2 was a left side of her w/c with eyes a 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 all activity occurring in the de of R2's door. p.m. NA-A and NA-B were R2 and lying the resident down I. R2's bottom was observed 2's sacral/coccyx area (located vertebral spinal column) was nded to the right and left ad barrier cream on it which arance. The reddened area on ttocks was approximately 8 side though did not appear to re also two smaller areas he right buttock and one on						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/06/2021 APPROVED 0938-0391
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F 686	the left buttock) with may have been oper with the cream cover R2's bottom had pro- up but now was loo NA-B confirmed R2 repositioning sched kiosk would alert the been repositioned a When interviewed of member (FM)-A ind residents up so ear prefer staff to lay R2 recliner after breakd change the weight p stated ideally she wher recliner or bed more When interviewed of confirmed she had and gotten the resid further confirmed R placed in her recliner as that was what the relayed to her. When interviewed of director of nursing ( for R2's repositionin every 2 hours as a confirmed the resid offloaded within the should have been la	ge 4 nin 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 ule 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 licated the staff get the ly in the morning that she'd 2 down or place her in the fast and before activities, to pattern on her tailbone. FM-A rould like to see R2 put into eakfast from 8:00 a.m. to t her up so she can attend an , then lay her down again. 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 2 was repositioned and er at approximately 9:20 a.m. e other staff on the unit had	F 6	36			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/06/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245369	B. WING				C 0 <b>3/2021</b>
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST MAR	KS LIVING				00 - 15TH AVENUE SOUTHWEST NUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	reviewed R2's last v 5/26/21, and confirm had a stage II press buttock measuring DON was asked to approximately 2:45 observed with the E come off the area a color surrounding th upper right and left reddened skin was there were 2 closed one open macerate measuring 0.8 cm > there would need to completed with the assessment and m DON further stated morning, wound ma ulcers had been ide and would be a pro- The policy titled Pre- revised April 2020, residents with or at individualized scheet interdisciplinary car for repositioning ba factors and current Evaluate, report and in the skin. Review	ge 5 wound/skin assessment dated ned 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 nd now appeared bright red in ne 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 (0.6 cm. DON confirmed be more education nursing staff related to easuring of pressure ulcers. during the QAPI meeting that anagement and pressure entified as areas of concern ject moving forward. evention of Pressure Injuries, indicated: Reposition all risk of pressure injuries on an dule, as determined by the e team. Choose a frequency sed on the resident's risk clinical proactive guidelines. d document potential changes the interventions and iveness on an ongoing basis.	F 6	\$86			

Facility ID: 00394

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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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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.

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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

Minneso	linnesota Department of Health									
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED				
		00394	B. WING		C 06/03/2021					
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE						
ST MARI	<b>KS LIVING</b>	400 - 15TH AUSTIN, M		OUTHWEST						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE				
2 000	Initial Comments		2 000							
	*****ATTEI	NTION*****								
	NH LICENSING	CORRECTION ORDER								
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been								
	that may result from orders provided that 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 Hea found NOT in comp Licensure. Please i of correction you ha identify the date wh	"S: aint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was bliance with the MN State ndicate in your electronic plan ave reviewed these orders and en they will be completed.								
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 07/01/21				

Electronically Signed

STATE FORM

If continuation sheet 1 of 8

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00394	B. WING			C 03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ST MAR	<b>KS LIVING</b>		H AVENUE SC MN 55912	DUTHWEST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:	laint was found to be H5369112C (MN00066458) er issued at 4658.0525				
	The following complaint was found to be SUBSTANTIATED: H5369111C (MN00073210), however, NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies"					
listed in the "Summary Statement of Deficiencie column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not me as evidence by." Following the surveyor's finding are the Suggested Method of Correction and Time Period for Correction. 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						
	receipt of State lice the Minnesota Depa Informational Bullet https://www.health.	nsure orders consistent with artment of Health in 14-01, available at				
	orders are delineated Department of Hea you electronically.	d on the attached Minnesota th orders being submitted to Although no plan of correction ate Statutes/Rules, please				
	enter the word "CO available for text. Ye electronic State lice	RRECTED" in the box ou must then indicate in the ensure process, under the				
		I date, the date your orders will o electronically submitting to				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00394	B. WING		C 03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
ST MAR	KS LIVING	400 - 15TH AUSTIN, M		OUTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 pa	ge 2	2 000		
	is enrolled in ePOC	artment of Health. The facility and therefore a signature is pottom of the first page of			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.			
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905		8/3/21
	positioned in good l of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	g. Residents must be body alignment. The position to change their own position t least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.			
	by: Based on observati review the facility fa accurately assesse was offered for 1 of pressure ulcers. Findings include: R2's Face Sheet pr diagnoses of Alzhei with long term use	ent is not met as evidenced on, interview, and document tiled to ensure skin was d and timely repositioning '3 residents (R2) reviewed for inted 6/2/21, indicated mer's disease, type 2 diabetes of insulin, and atrial fibrillation rapid heart rate) with long		How corrective action will be accomplished for those residents found to have been affected by the deficient practice? The CNAs for R2 were educated on timely repositioning. (NA-A and NA-B) R2 did not suffer any adverse events since identifying deficient practice. CNA and nursing staff were educated on 5/10/21, 5/13/21, and 6/23/21 regarding timely skin assessments, timely repositioning, pressure ulcers, immobility, and skin breakdown. How will the facility identify other residents having the potential to be	9

6899

STATEMENT O	Department of He F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
		00394	B. WING		C 06/0	; 3/2021
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		400 - 15T	H AVENUE S	SOUTHWEST		
ST MARKS	LIVING	AUSTIN, I	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 905 Co	ontinued From pa	ge 3	2 905			
R2 as mex loo pe wa ar (P sh wi op R2 re din pr ind br ar ob R2 Ri ind fol ha pr R2 Ri ind fol ha pr R2 Ri ce pr R2 Ri ce pr R2 Ri ce pr R2 Ri ce pr R2 Ri ce pr R2 Ri ce re c c c c	2's annual Minimu sessment dated s oderate cognitive tensive assistance comotion on/off un rsonal hygiene. The sisten of allow open ulcer without slough. May ben/ruptured serun 2's care plan print quired assistance rected staff to rep essure areas on the dicated weekly tre- clude measureme eakdown's width, id exudate and ar oservations. 2's Braden Scale f sk dated 5/26/21, dicating moderate 2's current physici dicated to offload r at least one hou as pressure area t essure applied to 2's Weekly Ulcer/o ol dated 5/26/21, ht buttock stage b ntimeter (cm) by essure ulcer mea	Im Data Set (MDS) 5/26/21, indicated R2 had impairment, required with bed mobility, transfer, nit, dressing, toilet use, and The MDS further indicated R2 ntinent of bowel and bladder, g stage II pressure ulcers ss of dermis presenting as a with red or pink wound bed, v also present as an intact or m filled blister) ed 6/2/21, indicated R2 to turn/reposition, and osition frequently due to bottom. The care plan further eatment documentation was to ent of each area of skin length, depth, type of tissue by other notable changes or for Predicting Pressure Sore included a score of 14, e risk for pressure ulcers. an orders printed 6/2/21, resident by laying down in bed r after every meal. Resident o coccyx. Ensure no		affected by the same deficient p Prompts placed into the TAR to nursing staff that a skin assess be completed. DON or designed completing weekly audits for sk wound completion on all resider residents currently in the facility a care plan review completed. S assessments will be reviewed for compliance with policy. Signage bathing areas as a visual to ale the nurse complete skin assess What measures will be put into systemic changes made, to ensi- the deficient practice will not red and nursing staff were educated 5/10/21, 5/13/21, and 6/23/21 re- timely skin assessments, timely repositioning, pressure ulcers, i and skin breakdown. Signage a bathing areas as a visual to ale the nurse complete skin assess Prompts placed into the TAR to nursing staff that a skin assess be completed. Audits will be con- using an audit tool to review: we assessments complete in comp policy and residents are reposit timely manner per care plan. He facility will monitor its corrective ensure that the deficient practic corrected and will not recur. Re Audits to be conducted on all sh or designee will review reposition two times per week for one mon- compliance, weekly skin assess audits, and DON or designee will residents weekly for one month will be provided to specific staff as needed and audits will be reference.	alert ment is to e is in and hts. All have had Skin or e added to rt to have ment. place, or sure that cur? CNA d on egarding mobility, dded to rt to have sment. alert ment is to nducted eekly skin blance with ioned in a ow the actions to e is being positioning nifts: DON oning audits nth for sment ill audit all . Education	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMPI	_ETED
		00394	B. WING			3/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST MARI	KS LIVING		HAVENUE S MN 55912	SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	ge 4	2 905			
	formation of granula intermediate step in full-thickness woun 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	Arresent (beefy red: The ation tissue is thought to be an in the healing process of ds. Wound has to be a Stage oble to have granulation Ant weekly Ulcer. Complex in tool dated 5/26/21 for R2, ent had 2 stage II pressure cm x 5 cm, upon observation is were observed to be in on each side of the buttock skin documentation indicated f macerated skin with open s.		facility's QAPI for further m recommendations, or follow administrator will be respon obtaining and substantiating	be corrected immediately, education will be provided, dings will be submitted to the l for further monitoring, ttions, or follow up. The will be responsible for d substantiating substantial Dates corrective action will be	
	was conducted. At a sitting in a wheelch w/c approximately f common area of the a.m., a nursing ass taking R2 in her w/c breakfast. At 8:08 the common area of At 8:20 a.m., R2 was in her w/c in the cor unit. At 8:35 a.m., I (LPN)-A propelled F medication then ret area within two min slumped over to the closed and appeare a.m., R2 was taken transferred into her	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 c to the dining room for 8 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 urned 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.				
		a.m. R2 was observed resting om. There was an exercise				

ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00394	B. WING			C 03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST MARI	<b>KS LIVING</b>		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 905	Continued From pa	age 5	2 905			
	and balloon volleyb common area outs	all activity occurring in the ide of R2's door.				
	observed toileting F after the lunch mea prior to toileting. R near the bottom of reddened and exter buttocks; the area f lightened the appea the right and left but cm x 5 cm on each be open. There we observed (one on ti the left buttock) wit may have been ope with the cream cove R2's bottom had pr up but now was loo NA-B confirmed R2 repositioning scheet kiosk would alert the been repositioned a When interviewed of member (FM)-A incor residents up so ear prefer staff to lay R recliner after break change the weight stated ideally she w her recliner after br 10:00 a.m., then ge activity, go to lunch FM-A further stated	9 p.m. NA-A and NA-B were R2 and lying the resident down al. R2's bottom was observed 2's sacral/coccyx area (located vertebral spinal column) was nded to the right and left had barrier cream on it which arance. The reddened area or attocks was approximately 8 side though did not appear to be also two smaller areas he right buttock and one on hin the reddened area that en but was difficult to assess ering them. NA-B indicated eviously pretty much cleared oking worse again. NA-A and 2 was on an every two hour dule and when charting in the nem 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 rly in the morning that she'd 2 down or place her in the fast and before activities, to pattern on her tailbone. FM-A would like to see R2 put into reakfast from 8:00 a.m. to et her up so she can attend an l, then lay her down again. I R2 shouldn't be in her re than 2 hours during the day.				

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00394		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
					C 06/03/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST MARI	KS LIVING		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
2 905	Continued From page 6		2 905			
	and gotten the resident up for the day. NA-B further confirmed R2 was repositioned and placed in her recliner at approximately 9:20 a.m. as that was what the other staff on the unit had relayed to her.					
	director of nursing for R2's repositionin every 2 hours as a confirmed the resid offloaded within the should have been I she could have got reviewed R2's last 5/26/21, and confirth had a stage II press buttock measuring DON was asked to approximately 2:45 observed with the I come off the area a color surrounding t upper right and left reddened skin was there were 2 closed one open macerate measuring 0.8 cm there would need to completed with the assessment and m DON further stated morning, wound ma ulcers had been ide and would be a pro-	on 6/2/21, at 2:29 p.m. the (DON) stated her expectation ng schedule would be at least standard of care. DON lent should have been a 2-hour timeframe and also ayed down after breakfast so ten 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 DON. The barrier cream had and now appeared bright red in he sacral/coccyx area and buttock near the coccyx. The intact though within the area d small macerated areas and ed area on the left buttock x 0.6 cm. DON confirmed o be more education nursing staff related to reasuring of pressure ulcers. I during the QAPI meeting that anagement and pressure entified as areas of concern ject moving forward.				
	revised April 2020, residents with or at	evention of Pressure Injuries, indicated: Reposition all risk of pressure injuries on an dule, as determined by the				

Minnesota Department of Health           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		С	
		00394	B. WING			03/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
T MARK	S LIVING		TH AVENUE SC MN 55912	DUTHWEST		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		SC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 905	Continued From page 7		2 905			
	for repositioning ba factors and current Evaluate, report an in the skin. Review strategies for effect SUGGESTED ME The director of nurs review policy and p assessment and de ensure resident new educate staff on po monitor care to ens designee could rev Assurance Commit	re team. Choose a frequency ised on the resident's risk clinical proactive guidelines. d document potential changes withe interventions and tiveness on an ongoing basis. THOD OF CORRECTION: sing (DON) or designee could procedures for pressure ulcer elivery of resident care to eds are met. The DON could blicies and procedure and sure implemented. The DON o iew findings with facility Quality ttee. R CORRECTION: Twenty-one	r /			