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

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).

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:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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 06/03/2021

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	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 6/3/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5369112C (MN00066458), with a deficiency cited at F686. The following complaint was found to be SUBSTANTIATED: H5369111C (MN00073210), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		8/3/21

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

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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure skin was accurately assessed and timely repositioning was offered for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's Face Sheet printed 6/2/21, indicated diagnoses of Alzheimer's disease, type 2 diabetes with long term use of insulin, and atrial fibrillation (irregular and often rapid heart rate) with long term use of aspirin. R2's annual Minimum Data Set (MDS) assessment dated 5/26/21, indicated R2 had moderate cognitive impairment, required extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated R2 was frequently incontinent of bowel and bladder, and had two existing stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister) R2's care plan printed 6/2/21, indicated R2 required assistance to turn/reposition, and directed staff to reposition frequently due to	F 686	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 affected by the same deficient practice? Prompts placed into the TAR to alert nursing staff that a skin assessment is to be completed. DON or designee is completing weekly audits for skin and wound completion on all residents. All residents currently in the facility have had a care plan review completed. Skin assessments will be reviewed for compliance with policy. Signage added to bathing areas as a visual to alert to have the nurse complete skin assessment. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? CNA and nursing staff were educated on 5/10/21, 5/13/21, and	

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F 686	Continued From page 2 pressure areas on bottom. The care plan further indicated weekly treatment documentation was to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's Braden Scale for Predicting Pressure Sore Risk dated 5/26/21, included a score of 14, indicating moderate risk for pressure ulcers. R2's current physician orders printed 6/2/21, indicated to offload resident by laying down in bed for at least one hour after every meal. Resident has pressure area to coccyx. Ensure no pressure applied to this area. R2's Weekly Ulcer/Complex Wound Observation Tool dated 5/26/21, indicated the resident had a right buttock stage II pressure ulcer measuring 8 centimeter (cm) by (x) 5 cm; and a left buttock pressure ulcer measuring 8 cm x 5 cm. The assessment further indicated there was granulation tissue present (beefy red: The formation of granulation tissue is thought to be an intermediate step in the healing process of full-thickness wounds. Wound has to be a Stage III, IV, or Unstageable to have granulation present). Although the current weekly Ulcer. Complex Wound Observation tool dated 5/26/21 for R2, indicated the resident had 2 stage II pressure ulcers measuring 8 cm x 5 cm, upon observation on 6/3/21, the areas were observed to be reddened area upon on each side of the buttock and not open. Prior skin documentation indicated R2 had a history of macerated skin with open areas upon buttocks.	F 686	6/23/21 regarding timely skin assessments, timely repositioning, pressure ulcers, immobility, and skin breakdown. Signage added to bathing areas as a visual to alert to have the nurse complete skin assessment. Prompts placed into the TAR to alert nursing staff that a skin assessment is to be completed. Audits will be conducted using an audit tool to review: weekly skin assessments complete in compliance with policy and residents are repositioned in a timely manner per care plan. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Repositioning Audits to be conducted on all shifts: DON or designee will review repositioning audits two times per week for one month for compliance, weekly skin assessment audits, and DON or designee will audit all residents weekly for one month. Education will be provided to specific staff members as needed and audits will be reviewed for understanding of processes. Identified concerns will be corrected immediately, documented education will be provided, and audit findings will be submitted to the facility's QAPI for further monitoring, recommendations, or follow up. The administrator will be responsible for obtaining and substantiating substantial compliance. Dates corrective action will be completed: August 3, 2021	

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F 686	Continued From page 3 On 6/3/21, at 6:36 a.m. a continuous observation was conducted. At 6:36 a.m. R2 was observed sitting in a wheelchair (w/c) and self-propelling w/c approximately 10 feet from her room to the common area of the Golden Oak unit. At 7:25 a.m., a nursing assistant (NA) was observed taking R2 in her w/c to the dining room for breakfast. At 8:08 a.m., R2 was brought back to the common area of the Golden Oak unit by staff. At 8:20 a.m., R2 was observed sleeping/napping in her w/c in the common area of the Golden Oak unit. At 8:35 a.m., licensed practical nurse (LPN)-A propelled R2 into her room to administer medication then returned R2 back to the common area within two minutes. At 9:03 a.m., R2 was slumped over to the left side of her w/c with eyes closed and appeared to be sleeping. At 9:32 a.m., R2 was taken into her room by staff and transferred into her recliner. R2 was not offered repositioning for 2 hours and 56 minutes. On 6/3/21, at 10:30 a.m. R2 was observed resting in recliner in her room. There was an exercise 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 toileting 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	F 686		

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F 686	Continued From page 4	F 686		

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 recliner after breakfast and before activities, to change the weight pattern on her tailbone. FM-A stated ideally she would like to see R2 put into her recliner 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 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.

When interviewed on 6/2/21, at 2:29 p.m. the director of nursing (DON) stated her expectation for R2's repositioning schedule would be at least every 2 hours as a standard of care. DON confirmed the resident should have been offloaded within the 2-hour timeframe and also should have been layed down after breakfast so she could have gotten up for the activity. DON

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F 686	Continued From page 5 reviewed R2's last wound/skin assessment dated 5/26/21, and confirmed it indicated the resident had a stage II pressure ulcer on the right and left buttock measuring 8 cm x 5 cm on each side; DON was asked to observe R2's bottom. At approximately 2:45 p.m. R2's bottom was observed with the DON. The barrier cream had come off the area and now appeared bright red in color surrounding the sacral/coccyx area and upper right and left buttock near the coccyx. The reddened skin was intact though within the area there were 2 closed small macerated areas and one open macerated area on the left buttock measuring 0.8 cm x 0.6 cm. DON confirmed there would need to be more education completed with the nursing staff related to assessment and measuring of pressure ulcers. DON further stated during the QAPI meeting that morning, wound management and pressure ulcers had been identified as areas of concern and would be a project moving forward. The policy titled Prevention of Pressure Injuries, revised April 2020, indicated: Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the 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.	F 686		

DEPARTMENT OF HEALTH

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 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:

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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5369112C (MN00066458) with a licensing order issued at 4658.0525 Subp.4. 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" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings 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/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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	00394	A. BUILDING: _____ B. WING _____	C 06/03/2021

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure skin was accurately assessed and timely repositioning was offered for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2's Face Sheet printed 6/2/21, indicated diagnoses of Alzheimer's disease, type 2 diabetes with long term use of insulin, and atrial fibrillation (irregular and often rapid heart rate) with long term use of aspirin.	2 905	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	8/3/21

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2 905	Continued From page 3 R2's annual Minimum Data Set (MDS) assessment dated 5/26/21, indicated R2 had moderate cognitive impairment, required extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene. The MDS further indicated R2 was frequently incontinent of bowel and bladder, and had two existing stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister) R2's care plan printed 6/2/21, indicated R2 required assistance to turn/reposition, and directed staff to reposition frequently due to pressure areas on bottom. The care plan further indicated weekly treatment documentation was to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's Braden Scale for Predicting Pressure Sore Risk dated 5/26/21, included a score of 14, indicating moderate risk for pressure ulcers. R2's current physician orders printed 6/2/21, indicated to offload resident by laying down in bed for at least one hour after every meal. Resident has pressure area to coccyx. Ensure no pressure applied to this area. R2's Weekly Ulcer/Complex Wound Observation Tool dated 5/26/21, indicated the resident had a right buttock stage II pressure ulcer measuring 8 centimeter (cm) by (x) 5 cm; and a left buttock pressure ulcer measuring 8 cm x 5 cm. The assessment further indicated there was	2 905	affected by the same deficient practice? Prompts placed into the TAR to alert nursing staff that a skin assessment is to be completed. DON or designee is completing weekly audits for skin and wound completion on all residents. All residents currently in the facility have had a care plan review completed. Skin assessments will be reviewed for compliance with policy. Signage added to bathing areas as a visual to alert to have the nurse complete skin assessment. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? 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. Signage added to bathing areas as a visual to alert to have the nurse complete skin assessment. Prompts placed into the TAR to alert nursing staff that a skin assessment is to be completed. Audits will be conducted using an audit tool to review: weekly skin assessments complete in compliance with policy and residents are repositioned in a timely manner per care plan. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Repositioning Audits to be conducted on all shifts: DON or designee will review repositioning audits two times per week for one month for compliance, weekly skin assessment audits, and DON or designee will audit all residents weekly for one month. Education will be provided to specific staff members as needed and audits will be reviewed for	

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2 905	Continued From page 4 granulation tissue present (beefy red: The formation of granulation tissue is thought to be an intermediate step in the healing process of full-thickness wounds. Wound has to be a Stage III, IV, or Unstageable to have granulation present). Although the current weekly Ulcer. Complex Wound Observation tool dated 5/26/21 for R2, indicated the resident had 2 stage II pressure ulcers measuring 8 cm x 5 cm, upon observation on 6/3/21, the areas were observed to be reddened area upon on each side of the buttock and not open. Prior skin documentation indicated R2 had a history of macerated skin with open areas upon buttocks. On 6/3/21, at 6:36 a.m. a continuous observation was conducted. At 6:36 a.m. R2 was observed sitting in a wheelchair (w/c) and self-propelling w/c approximately 10 feet from her room to the common area of the Golden Oak unit. At 7:25 a.m., a nursing assistant (NA) was observed taking R2 in her w/c to the dining room for breakfast. At 8:08 a.m., R2 was brought back to the common area of the Golden Oak unit by staff. At 8:20 a.m., R2 was observed sleeping/napping in her w/c in the common area of the Golden Oak unit. At 8:35 a.m., licensed practical nurse (LPN)-A propelled R2 into her room to administer medication then returned R2 back to the common area within two minutes. At 9:03 a.m., R2 was slumped over to the left side of her w/c with eyes closed and appeared to be sleeping. At 9:32 a.m., R2 was taken into her room by staff and transferred into her recliner. R2 was not offered repositioning for 2 hours and 56 minutes. On 6/3/21, at 10:30 a.m. R2 was observed resting in recliner in her room. There was an exercise	2 905	understanding of processes. Identified concerns will be corrected immediately, documented education will be provided, and audit findings will be submitted to the facility's QAPI for further monitoring, recommendations, or follow up. The administrator will be responsible for obtaining and substantiating substantial compliance. Dates corrective action will be completed: August 3, 2021	

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2 905	Continued From page 5 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 toileting 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 recliner after breakfast and before activities, to change the weight pattern on her tailbone. FM-A stated ideally she would like to see R2 put into her recliner 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	2 905		

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2 905	Continued From page 6 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. When interviewed on 6/2/21, at 2:29 p.m. the director of nursing (DON) stated her expectation for R2's repositioning schedule would be at least every 2 hours as a standard of care. DON confirmed the resident should have been offloaded within the 2-hour timeframe and also should have been layed down after breakfast so she could have gotten up for the activity. DON reviewed R2's last wound/skin assessment dated 5/26/21, and confirmed it indicated the resident had a stage II pressure ulcer on the right and left buttock measuring 8 cm x 5 cm on each side; DON was asked to observe R2's bottom. At approximately 2:45 p.m. R2's bottom was observed with the DON. The barrier cream had come off the area and now appeared bright red in color surrounding the sacral/coccyx area and upper right and left buttock near the coccyx. The reddened skin was intact though within the area there were 2 closed small macerated areas and one open macerated area on the left buttock measuring 0.8 cm x 0.6 cm. DON confirmed there would need to be more education completed with the nursing staff related to assessment and measuring of pressure ulcers. DON further stated during the QAPI meeting that morning, wound management and pressure ulcers had been identified as areas of concern and would be a project moving forward. The policy titled Prevention of Pressure Injuries, revised April 2020, indicated: Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the	2 905		

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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.	2 905		