

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).

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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<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 | IPLE CONSTRUCTION   | COM  | E SURVEY<br>IPLETED        |
|                          |  | 245369   | B. WING _           |   |      | C<br>03/2021               |
| NAME OF F                | PROVIDER OR SUPPLIER   |  | ·                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | -    |                            |
| ST MAR                   | <b>KS LIVING</b>   |  |                     | 400 - 15TH AVENUE SOUTHWEST<br>AUSTIN, MN 55912   |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | rs   | F 00                | 00  |      |                            |
|                          | conducted at your f to be NOT in comp  | ard abbreviated survey was<br>acility. Your facility was found<br>liance with the requirements of<br>art B, Requirements for Long<br>s.  |                     |   |      |                            |
|                          |  | plaint was found to be<br>H5369112C (MN00066458),<br>red at F686.  |                     |   |      |                            |
|                          | SUBSTANTIATED:<br>however NO deficie   | laint was found to be<br>H5369111C (MN00073210),<br>encies were cited due to<br>ed by the facility prior to survey.  |                     |   |      |                            |
|                          | as your allegation of<br>Departments accept<br>enrolled in ePOC, y<br>at the bottom of the | f correction (POC) will serve<br>of compliance upon the<br>otance. Because you are<br>your signature is not required<br>a first page of the CMS-2567<br>ic submission of the POC will<br>tion of compliance. |                     |   |      |                            |
| F 686<br>SS=D            | onsite revisit of you<br>validate that substa<br>regulations has bee<br>Treatment/Svcs to  | Prevent/Heal Pressure Ulcer  | F 68                | 36  |      | 8/3/21                     |
|                          | resident, the facility<br>(i) A resident receiv<br>professional standa                     | sure ulcers.<br>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<br>& MEDICAID SERVICES  |                    |      |   | FORM  | 07/06/2021<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|------|---|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |      | E CONSTRUCTION  | (X3) DATE<br>COM  | E SURVEY<br>PLETED                  |
|                          |   | 245369   | B. WING            |      |   |   | C<br>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<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 686                    | demonstrates that t<br>(ii) A resident with p<br>necessary treatmer<br>with professional st<br>promote healing, pr<br>new ulcers from de<br>This REQUIREMEN<br>by:<br>Based on observat<br>review the facility fa<br>accurately assesse<br>was offered for 1 of<br>pressure ulcers.<br>Findings include:<br>R2's Face Sheet pr<br>diagnoses of Alzhei<br>with long term use of<br>(irregular and often<br>term use of aspirin.<br>R2's annual Minimu<br>assessment dated a<br>moderate cognitive<br>extensive assistance<br>locomotion on/off up<br>personal hygiene.<br>was frequently inco<br>and had two existin<br>(Partial thickness lo<br>shallow open ulcer<br>without slough. May<br>open/ruptured serue<br>R2's care plan print<br>required assistance | dividual's clinical condition<br>hey were unavoidable; and<br>pressure ulcers receives<br>at and services, consistent<br>andards of practice, to<br>revent infection and prevent<br>veloping.<br>NT is not met as evidenced<br>tion, interview, and document<br>tiled to ensure skin was<br>d and timely repositioning<br>3 residents (R2) reviewed for<br>inted 6/2/21, indicated<br>mer's disease, type 2 diabetes<br>of insulin, and atrial fibrillation<br>rapid heart rate) with long<br>m Data Set (MDS)<br>5/26/21, indicated R2 had<br>impairment, required<br>the MDS further indicated R2<br>ntinent of bowel and bladder,<br>g stage II pressure ulcers<br>os of dermis presenting as a<br>with red or pink wound bed,<br>y also present as an intact or<br>m filled blister)<br>ed 6/2/21, indicated R2<br>e to turn/reposition, and | F                  | \$86 | How corrective action will be<br>accomplished for those residents for<br>have been affected by the deficient<br>practice? The CNAs for R2 were<br>educated on timely repositioning. (N<br>and NA-B) R2 did not suffer any ad<br>events since identifying deficient pr<br>CNA and nursing staff were educate<br>5/10/21, 5/13/21, and 6/23/21 regar<br>timely skin assessments, timely<br>repositioning, pressure ulcers, imm<br>and skin breakdown. How will the fa-<br>identify other residents having the<br>potential to be affected by the same<br>deficient practice? Prompts placed<br>the TAR to alert nursing staff that a<br>assessment is to be completed. DC<br>designee is completing weekly aud<br>skin and wound completion on all<br>residents. All residents currently in<br>facility have had a care plan review<br>completed. Skin assessments will b<br>reviewed for compliance with policy<br>Signage added to bathing areas as<br>visual to alert to have the nurse cor<br>skin assessment. What measures of<br>put into place, or systemic changes<br>to ensure that the deficient practice<br>not recur? CNA and nursing staff w | NA-A<br>verse<br>actice.<br>ed on<br>rding<br>obility,<br>acility<br>e<br>into<br>skin<br>DN or<br>its for<br>the<br>c<br>a<br>mplete<br>will be<br>s made,<br>will |                                     |
|                          | shallow open ulcer<br>without slough. May<br>open/ruptured serue<br>R2's care plan print<br>required assistance   | with red or pink wound bed,<br>also present as an intact or<br>m filled blister)<br>ed 6/2/21, indicated R2  |                    |      | Signage added to bathing areas as<br>visual to alert to have the nurse cor<br>skin assessment. What measures<br>put into place, or systemic changes<br>to ensure that the deficient practice  | a<br>mplete<br>will be<br>made,<br>will   |                                     |

Facility ID: 00394

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|                          | 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<br>USTIN, MN 55912  |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                         | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)              | ID<br>PREFIX<br>TAG |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETIOI<br>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.<br>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<br>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<br>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<br>n the healing process of                                      |                     |  | reviewed for understanding of proc<br>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,<br>ent had 2 stage II pressure                                       |                     |  | for obtaining and substantiating<br>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<br>areas upon buttock | f macerated skin with open  |                     |  |  |           |                            |
|                          |  |   |                     |  |  |           |                            |

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |    |   | FORM                | APPROVED<br>0938-0391 |  |
|--------------------------|---|--|--------------------|----|---|---------------------|-----------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |    |   | (X3) DATE           | E SURVEY<br>PLETED    |  |
|                          |   | 245369   | B. WING            |    |   |                     | C<br>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<br>AUSTIN, MN 55912  |                     |                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x  | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>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<br>6:36 a.m. R2 was observed<br>air (w/c) and self-propelling<br>10 feet from her room to the<br>a Golden Oak unit. At 7:25<br>istant (NA) was observed<br>to the dining room for<br>a.m., R2 was brought back to<br>if the Golden Oak unit by staff.<br>as observed sleeping/napping<br>mmon area of the Golden Oak<br>icensed practical nurse<br>R2 into her room to administer<br>urned R2 back to the common<br>utes. At 9:03 a.m., R2 was<br>a left side of her w/c with eyes<br>a to be sleeping. At 9:32<br>into her room by staff and<br>recliner. R2 was not offered<br>nours and 56 minutes.<br>a.m. R2 was observed resting<br>om. There was an exercise<br>all activity occurring in the<br>de of R2's door.<br>p.m. NA-A and NA-B were<br>R2 and lying the resident down<br>I. R2's bottom was observed<br>2's sacral/coccyx area (located<br>vertebral spinal column) was<br>nded to the right and left<br>ad barrier cream on it which<br>arance. The reddened area on<br>ttocks was approximately 8<br>side though did not appear to<br>re also two smaller areas<br>he right buttock and one on |                    |    |   |                     |                       |  |

Facility ID: 00394

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PRINTED: 07/06/2021

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |    |   | FORM             | 07/06/2021<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|----|---|------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 |    | E CONSTRUCTION  | (X3) DATE<br>COM | E SURVEY<br>PLETED                  |
|                          |  | 245369  | B. WING _           |    |   |                  | C<br>0 <b>3/2021</b>                |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                     | ST | TREET ADDRESS, CITY, STATE, ZIP CODE  |                  |                                     |
| ST MAR                   | KS LIVING  |   |                     |    | 00 - 15TH AVENUE SOUTHWEST<br>USTIN, MN 55912   |                  |                                     |
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| F 686                    | the left buttock) with<br>may have been oper<br>with the cream cover<br>R2's bottom had pro-<br>up but now was loo<br>NA-B confirmed R2<br>repositioning sched<br>kiosk would alert the<br>been repositioned a<br>When interviewed of<br>member (FM)-A ind<br>residents up so ear<br>prefer staff to lay R2<br>recliner after breakd<br>change the weight p<br>stated ideally she wher<br>recliner or bed more<br>When interviewed of<br>confirmed she had<br>and gotten the resid<br>further confirmed R<br>placed in her recliner<br>as that was what the<br>relayed to her.<br>When interviewed of<br>director of nursing (<br>for R2's repositionin<br>every 2 hours as a<br>confirmed the resid<br>offloaded within the<br>should have been la | ge 4<br>nin the reddened area that<br>en but was difficult to assess<br>ering them. NA-B indicated<br>eviously pretty much cleared<br>king worse again. NA-A and<br>was on an every two hour<br>ule and when charting in the<br>em when the resident had last<br>and needed to be repositioned.<br>on 6/3/21, at 1:36 p.m. family<br>licated the staff get the<br>ly in the morning that she'd<br>2 down or place her in the<br>fast and before activities, to<br>pattern on her tailbone. FM-A<br>rould like to see R2 put into<br>eakfast from 8:00 a.m. to<br>t her up so she can attend an<br>, then lay her down again.<br>R2 shouldn't be in her<br>e than 2 hours during the day.<br>on 6/2/21, at 2:11 p.m. NA-B<br>performed R2's morning cares<br>dent up for the day. NA-B<br>2 was repositioned and<br>er at approximately 9:20 a.m.<br>e other staff on the unit had | F 6                 | 36 |   |                  |                                     |

If continuation sheet Page 5 of 6

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |      |   | FORM             | 07/06/2021<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|------|---|------------------|-------------------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |      | E CONSTRUCTION  | (X3) DATE<br>COM | E SURVEY<br>PLETED                  |
|                          |   | 245369   | B. WING            |      |   |                  | C<br>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<br>NUSTIN, MN 55912  |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE             | (X5)<br>COMPLETION<br>DATE          |
| F 686                    | reviewed R2's last v<br>5/26/21, and confirm<br>had a stage II press<br>buttock measuring<br>DON was asked to<br>approximately 2:45<br>observed with the E<br>come off the area a<br>color surrounding th<br>upper right and left<br>reddened skin was<br>there were 2 closed<br>one open macerate<br>measuring 0.8 cm ><br>there would need to<br>completed with the<br>assessment and m<br>DON further stated<br>morning, wound ma<br>ulcers had been ide<br>and would be a pro-<br>The policy titled Pre-<br>revised April 2020,<br>residents with or at<br>individualized scheet<br>interdisciplinary car<br>for repositioning ba<br>factors and current<br>Evaluate, report and<br>in the skin. Review | ge 5<br>wound/skin assessment dated<br>ned it indicated the resident<br>sure ulcer on the right and left<br>8 cm x 5 cm on each side;<br>observe R2's bottom. At<br>p.m. R2's bottom was<br>OON. The barrier cream had<br>nd now appeared bright red in<br>ne sacral/coccyx area and<br>buttock near the coccyx. The<br>intact though within the area<br>I small macerated areas and<br>d area on the left buttock<br>(0.6 cm. DON confirmed<br>be more education<br>nursing staff related to<br>easuring of pressure ulcers.<br>during the QAPI meeting that<br>anagement and pressure<br>entified as areas of concern<br>ject moving forward.<br>evention of Pressure Injuries,<br>indicated: Reposition all<br>risk of pressure injuries on an<br>dule, as determined by the<br>e team. Choose a frequency<br>sed on the resident's risk<br>clinical proactive guidelines.<br>d document potential changes<br>the interventions and<br>iveness on an ongoing basis. | F 6                | \$86 |   |                  |                                     |

Facility ID: 00394

If continuation sheet Page 6 of 6



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.

Mitig

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

Electronically Signed

STATE FORM

If continuation sheet 1 of 8

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

| STATEMEN                 | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------|--|--------------------------|
|                          |   | 00394   | B. WING             |  | C<br>03/2021             |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY,        | STATE, ZIP CODE  |                          |
| ST MAR                   | KS LIVING   | 400 - 15TH<br>AUSTIN, M   |                     | OUTHWEST   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Continued From pa   | ge 2  | 2 000               |  |                          |
|                          | is enrolled in ePOC   | artment of Health. The facility<br>and therefore a signature is<br>pottom of the first page of  |                     |  |                          |
|                          | FOURTH COLUMN<br>"PROVIDER'S PLA<br>APPLIES TO FEDE   | RD THE HEADING OF THE<br>I WHICH STATES,<br>N OF CORRECTION." THIS<br>RAL DEFICIENCIES ONLY.<br>R ON EACH PAGE.   |                     |  |                          |
| 2 905                    | MN Rule 4658.052  | 5 Subp. 4 Rehab - Positioning   | 2 905               |  | 8/3/21                   |
|                          | positioned in good l<br>of residents unable<br>must be changed a<br>including periods of<br>been put to bed for<br>has documented th<br>hours during this tir   | g. Residents must be<br>body alignment. The position<br>to change their own position<br>t least every two hours,<br>time after the resident has<br>the night, unless the physician<br>at repositioning every two<br>ne period is unnecessary or<br>rdered a different interval.           |                     |  |                          |
|                          | by:<br>Based on observati<br>review the facility fa<br>accurately assesse<br>was offered for 1 of<br>pressure ulcers.<br>Findings include:<br>R2's Face Sheet pr<br>diagnoses of Alzhei<br>with long term use | ent is not met as evidenced<br>on, interview, and document<br>tiled to ensure skin was<br>d and timely repositioning<br>'3 residents (R2) reviewed for<br>inted 6/2/21, indicated<br>mer's disease, type 2 diabetes<br>of insulin, and atrial fibrillation<br>rapid heart rate) with long |                     | How corrective action will be<br>accomplished for those residents found to<br>have been affected by the deficient<br>practice? The CNAs for R2 were educated<br>on timely repositioning. (NA-A and NA-B)<br>R2 did not suffer any adverse events since<br>identifying deficient practice. CNA and<br>nursing staff were educated on 5/10/21,<br>5/13/21, and 6/23/21 regarding timely skin<br>assessments, timely repositioning,<br>pressure ulcers, immobility, and skin<br>breakdown. How will the facility identify<br>other residents having the potential to be | 9                        |

6899

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

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                   | LE CONSTRUCTION   | (X3) DATE<br>COMPI   | _ETED                   |
|--------------------------|---|--|-----------------------|---|--|-------------------------|
|                          |   | 00394  | B. WING               |   |  | 3/2021                  |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                       | STATE, ZIP CODE   |  |                         |
| ST MARI                  | KS LIVING   |  | HAVENUE S<br>MN 55912 | SOUTHWEST   |  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)                                  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLET<br>DATE |
| 2 905                    | Continued From pa   | ge 4   | 2 905                 |   |  |                         |
|                          | formation of granula<br>intermediate step in<br>full-thickness woun<br>III, IV, or Unstageal<br>present).<br>Although the currer<br>Wound Observation<br>indicated the reside<br>ulcers measuring 8<br>on 6/3/21, the areas<br>reddened area upo<br>and not open. Prior   | Arresent (beefy red: The<br>ation tissue is thought to be an<br>in the healing process of<br>ds. Wound has to be a Stage<br>oble to have granulation<br>Ant weekly Ulcer. Complex<br>in tool dated 5/26/21 for R2,<br>ent had 2 stage II pressure<br>cm x 5 cm, upon observation<br>is were observed to be<br>in on each side of the buttock<br>skin documentation indicated<br>f macerated skin with open<br>s.   |                       | facility's QAPI for further m<br>recommendations, or follow<br>administrator will be respon<br>obtaining and substantiating | be corrected immediately,<br>education will be provided,<br>dings will be submitted to the<br>l for further monitoring,<br>ttions, or follow up. The<br>will be responsible for<br>d substantiating substantial<br>Dates corrective action will be |                         |
|                          | was conducted. At a<br>sitting in a wheelch<br>w/c approximately f<br>common area of the<br>a.m., a nursing ass<br>taking R2 in her w/c<br>breakfast. At 8:08<br>the common area of<br>At 8:20 a.m., R2 was<br>in her w/c in the cor<br>unit. At 8:35 a.m., I<br>(LPN)-A propelled F<br>medication then ret<br>area within two min<br>slumped over to the<br>closed and appeare<br>a.m., R2 was taken<br>transferred into her | a.m. a continuous observation<br>6:36 a.m. R2 was observed<br>air (w/c) and self-propelling<br>10 feet from her room to the<br>e Golden Oak unit. At 7:25<br>istant (NA) was observed<br>c to the dining room for<br>8 a.m., R2 was brought back to<br>of the Golden Oak unit by staff.<br>as observed sleeping/napping<br>mmon area of the Golden Oak<br>licensed practical nurse<br>R2 into her room to administer<br>urned R2 back to the common<br>utes. At 9:03 a.m., R2 was<br>e left side of her w/c with eyes<br>ed to be sleeping. At 9:32<br>into her room by staff and<br>recliner. R2 was not offered<br>nours and 56 minutes. |                       |   |  |                         |
|                          |   | a.m. R2 was observed resting<br>om. There was an exercise  |                       |   |  |                         |

| ND PLAN                  | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          |  | COM            | E SURVEY<br>PLETED      |
|--------------------------|---|--|--------------------------|--|----------------|-------------------------|
|                          |   | 00394  | B. WING                  |  |                | C<br>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<br>MN 55912 | DUTHWEST   |                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 905                    | Continued From pa   | age 5  | 2 905                    |  |                |                         |
|                          | and balloon volleyb<br>common area outs   | all activity occurring in the ide of R2's door.  |                          |  |                |                         |
|                          | observed toileting F<br>after the lunch mea<br>prior to toileting. R<br>near the bottom of<br>reddened and exter<br>buttocks; the area f<br>lightened the appea<br>the right and left but<br>cm x 5 cm on each<br>be open. There we<br>observed (one on ti<br>the left buttock) wit<br>may have been ope<br>with the cream cove<br>R2's bottom had pr<br>up but now was loo<br>NA-B confirmed R2<br>repositioning scheet<br>kiosk would alert the<br>been repositioned a<br>When interviewed of<br>member (FM)-A incor<br>residents up so ear<br>prefer staff to lay R<br>recliner after break<br>change the weight<br>stated ideally she w<br>her recliner after br<br>10:00 a.m., then ge<br>activity, go to lunch<br>FM-A further stated | 9 p.m. NA-A and NA-B were<br>R2 and lying the resident down<br>al. R2's bottom was observed<br>2's sacral/coccyx area (located<br>vertebral spinal column) was<br>nded to the right and left<br>had barrier cream on it which<br>arance. The reddened area or<br>attocks was approximately 8<br>side though did not appear to<br>be also two smaller areas<br>he right buttock and one on<br>hin the reddened area that<br>en but was difficult to assess<br>ering them. NA-B indicated<br>eviously pretty much cleared<br>oking worse again. NA-A and<br>2 was on an every two hour<br>dule and when charting in the<br>nem when the resident had last<br>and needed to be repositioned<br>on 6/3/21, at 1:36 p.m. family<br>dicated the staff get the<br>rly in the morning that she'd<br>2 down or place her in the<br>fast and before activities, to<br>pattern on her tailbone. FM-A<br>would like to see R2 put into<br>reakfast from 8:00 a.m. to<br>et her up so she can attend an<br>l, then lay her down again.<br>I R2 shouldn't be in her<br>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<br>COMPLETED  |                 |                         |
|--|---|--|--------------------------|--|-----------------|-------------------------|
|  |   |  |                          |  | C<br>06/03/2021 |                         |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S          | TATE, ZIP CODE   |                 |                         |
| ST MARI  | KS LIVING   |  | TH AVENUE SC<br>MN 55912 | DUTHWEST   |                 |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                 | (X5)<br>COMPLET<br>DATE |
| 2 905  | Continued From page 6   |  | 2 905                    |  |                 |                         |
|  | and gotten the resident up for the day. NA-B<br>further confirmed R2 was repositioned and<br>placed in her recliner at approximately 9:20 a.m.<br>as that was what the other staff on the unit had<br>relayed to her.   |  |                          |  |                 |                         |
|  | director of nursing<br>for R2's repositionin<br>every 2 hours as a<br>confirmed the resid<br>offloaded within the<br>should have been I<br>she could have got<br>reviewed R2's last<br>5/26/21, and confirth<br>had a stage II press<br>buttock measuring<br>DON was asked to<br>approximately 2:45<br>observed with the I<br>come off the area a<br>color surrounding t<br>upper right and left<br>reddened skin was<br>there were 2 closed<br>one open macerate<br>measuring 0.8 cm<br>there would need to<br>completed with the<br>assessment and m<br>DON further stated<br>morning, wound ma<br>ulcers had been ide<br>and would be a pro- | on 6/2/21, at 2:29 p.m. the<br>(DON) stated her expectation<br>ng schedule would be at least<br>standard of care. DON<br>lent should have been<br>a 2-hour timeframe and also<br>ayed down after breakfast so<br>ten up for the activity. DON<br>wound/skin assessment dated<br>med it indicated the resident<br>sure ulcer on the right and left<br>8 cm x 5 cm on each side;<br>observe R2's bottom. At<br>p.m. R2's bottom was<br>DON. The barrier cream had<br>and now appeared bright red in<br>he sacral/coccyx area and<br>buttock near the coccyx. The<br>intact though within the area<br>d small macerated areas and<br>ed area on the left buttock<br>x 0.6 cm. DON confirmed<br>o be more education<br>nursing staff related to<br>reasuring of pressure ulcers.<br>I during the QAPI meeting that<br>anagement and pressure<br>entified as areas of concern<br>ject moving forward. |                          |  |                 |                         |
|  | revised April 2020, residents with or at  | evention of Pressure Injuries,<br>indicated: Reposition all<br>risk of pressure injuries on an<br>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<br>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<br>MN 55912 | DUTHWEST  |                 |                 |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID                       | PROVIDER'S PLAN OF                                      |                 | (X5)            |
| PRÉFIX<br>TAG  |   | SC IDENTIFYING INFORMATION   | PREFIX<br>TAG            | (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE |
| 2 905  | Continued From page 7   |  | 2 905                    |   |                 |                 |
|  | for repositioning ba<br>factors and current<br>Evaluate, report an<br>in the skin. Review<br>strategies for effect<br>SUGGESTED ME<br>The director of nurs<br>review policy and p<br>assessment and de<br>ensure resident new<br>educate staff on po<br>monitor care to ens<br>designee could rev<br>Assurance Commit | re team. Choose a frequency<br>ised on the resident's risk<br>clinical proactive guidelines.<br>d document potential changes<br>withe interventions and<br>tiveness on an ongoing basis.<br>THOD OF CORRECTION:<br>sing (DON) or designee could<br>procedures for pressure ulcer<br>elivery of resident care to<br>eds are met. The DON could<br>blicies and procedure and<br>sure implemented. The DON o<br>iew findings with facility Quality<br>ttee.<br>R CORRECTION: Twenty-one | r<br>/                   |   |                 |                 |