DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 17, 2022

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

RE: CCN: 245369
Cycle Start Date: January 10, 2022

Dear Administrator:

On January 24, 2022, we notified you a remedy was imposed. On February 10, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 28, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 8, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 24, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 10, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 17, 2022

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

Re: Reinspection Results
Event ID: KFKN12

Dear Administrator:

On February 10, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 10, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
January 24, 2022

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

RE: CCN: 245369
Cycle Start Date: January 10, 2022

Dear Administrator:

On January 10, 2022, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 10, 2022, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 8, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 8, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 8, 2022, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Marks Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 10, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted

to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 10, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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 64900
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 01/10/2022

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 1/6/22 through 1/10/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5369127C (MN00079842 and MN00079815) with deficiencies cited at F689. The survey resulted in an immediate jeopardy (IJ) at F689 when R1 had a fall from the mechanical lift that resulted in a head strike and a hospital transfer after staff involved in the mechanical lift transfer did not follow manufacturer's recommendations for safe transfers and the facility failed to assess staff were competent to use equipment safely. The immediate jeopardy began on 12/31/21 and the immediacy was removed on 1/7/22. The above findings constituted substandard quality of care and an extended survey was conducted from 1/7/22 to 1/10/22. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete comprehensive safe transfer assessments for 9 of 9 residents (R1, R2, R3, R4, R5, R6, R7, R8, and R9), ensure the appropriate sling size was used for safe transfer for 4 of 9 residents (R1, R6, R5, and R8), develop a consistent system for repair of mechanical lifts, and failed to assess staff competency to ensure safe transfers via full body mechanical lifts. The facility's failures resulted in actual falls with injury for 2 of 9 residents (R1, R6) and immediate jeopardy (IJ) situation for (R1). The immediate jeopardy began on 12/31/21, when R1 had a fall from the mechanical lift that resulted in a head strike and a hospital transfer after staff involved in the mechanical lift transfer did not follow manufacturer's recommendations for safe transfers and the facility failed to assess staff were competent to use equipment safely. The administrator and director of nursing were	F 689	How will Corrective action be accomplished for those residents found to have been affected by the deficient practice? Facility implemented a new sling size assessment tool on 1/7/22. Nurse Managers were trained by DON on the new assessment tool. In addition all residents were assessed for correct hoyer sling size in the event a hoyer is needed for that resident. Staff members involved with the hoyer incident were immediately verbally trained by DON. Residents were assessed on 1/7/22 for proper sling size. Care plans were adjusted to include appropriate sizing on 1/7/22. Care sheets were also updated to include appropriate size so direct care	1/28/22

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 01/10/2022

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 689	Continued From page 2 notified of the immediate jeopardy at 12:00 p.m. on 1/7/22. The immediate jeopardy was removed on 1/10/22, but non-compliance remained at scope and severity of E scope and severity level pattern which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1 R1's care plan for transfers dated 7/12/21, included, "The resident requires A2 [assist of 2] Hoyer transfers." and did not identify the size of sling appropriate for R1. The care plan for transfer revised on 1/5/22 included, "The resident requires A2 [assist of two] Hoyer transfers. Ensure proper sized sling is used, proper placement of sling straps and that Hoyer is functioning properly." The care plan did not identify the size of the sling. R1's care plan revised on 1/6/22, included the aforementioned however, directed staff to use a small sling. R1's quarterly Minimum Data Set (MDS) dated 10/18/21, identified that R1 had diagnoses that included dementia and R1's cognition was severely impaired. The MDS indicated R1 did not have verbal, physical, and rejection of care behaviors. The MDS also indicated R1 required assistance of two or more staff for transfers. R1's progress note dated 12/31/21, at 5:50 p.m. included, "Nurse called to residents' room at 3:10 p.m. by aide, and found resident lying in bed on her back with blood area under her head. She was awake. Aide stated she fell and hit her head on the right hoyer base. Nurse lifted head slightly to see swollen area to back center of head and a	F 689	staff would be aware of proper sling to use on 1/7/22. Facility removed the hoyer lift involved in incident from service on 12/31/21 until a comprehensive assessment of lift was conducted to determine proper functioning. All Nurses, TMA's, and CNA's were re-trained and competency tested on hoyer use prior to starting their next shift. New hoyer slings have been purchased and received from Ez-Way Inc. to ensure enough quantity of proper size for each resident. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents were assessed using the new sling size assessment tool on 1/7/22. Adjustments have been made to the care plans and care sheets to identify the correct sling size for each resident requiring a hoyer lift. All lifts were inspected on 12/31/21 to ensure proper functioning. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility implemented a new sling size assessment tool on 1/7/22 that will be	

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 01/10/2022

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 689	Continued From page 3 dark red spot about 4 inches wide with lighter color surrounding it. Nurse left to call 911 about 3:15 p.m." The note indicated R1 was transferred to the hospital around 3:45 p.m. and the nurse was informed by emergency room nurse that R1 would be discharged back to the facility with no stitches needed. A subsequent progress note at 8:51 p.m. indicated R1 had returned to the facility at 8:45 p.m.. Facility reported incident dated 12/31/21 at 4:27 p.m. indicated at 3:25 p.m. on 12/31/21, two staff were assisting R1 using a Hoyer (full body mechanical lift) to transfer R1 to the shower chair when the upper left side of the transfer sling slipped from Hoyer and R1 fell towards the ground hitting her head on the leg of the Hoyer. R1 was transferred to the hospital for further evaluation; R1 sustained a bump to the back of her head with a laceration. R1's record lacked evidence of a comprehensive assessment for sling size in accordance with manufacturer's recommendations for safe transfers. During the entrance conference on 1/6/22, at 9:15 a.m. with the director of nursing (DON) and administrator the DON provided a recapitulation of R1's fall from the lift and the facility's investigation and interventions to date. DON stated she immediately received the call from the nurse and immediately began her investigation. DON indicated based on interviews, R1 was being lifted off the bed, the sling started swaying, R1 leaned to the left, R1's upper body then rolled out of the sling which caused R1's head strike on the leg of the lift. DON indicated the head strike resulted in a hematoma to the back of her head	F 689	used for all residents needing hoyer transfers. Assessments will be completed on admission, quarterly, and on any resident that has a significant change of health (in line with MDS assessments). Additional slings were purchased so the facility has sufficient supply for when some are being laundered. Nurse Managers were trained by DON on the new assessment tool. In addition all residents were assessed for correct hoyer sling size in the event a hoyer is needed for that resident. All Nurses, TMA's, and CNA's were competency tested on hoyer use prior to starting their next shift. Nurses were trained to test competencies of TMA's and Nurses Aides on 1/7/22. Maintenance personnel will be trained again on the use of TELS on 1/28/22. Facility created a new google sheet to track and monitor the progress of employee competency testing. The EZ stand manufacturer will be in the building on 1/26/22 to train direct care staff/therapy on proper lift use, and maintenance staff on routine maintenance. Policies and Procedures were reviewed with no modifications needed at this time. How will the facility monitor its corrective	

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 01/10/2022

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 689	Continued From page 4 with a small laceration and was transferred to hospital for further evaluation and returned later that evening with no new orders. DON indicated the interviews were inconsistent in that nursing assistant (NA)-F stated both aides were in the room at the time of the transfer, however, NA-G stated he was just entering the room as NA-F was lifting R1 off the bed and could not get to R1 before she rolled out of the sling. DON stated she immediately provided both aides verbal education on responsibilities of 2nd person during transfers and verification of the sling loops connected to the lift. DON stated it is required 2 staff are present during hoyer transfers; the second person checks to ensure the sling is positioned correctly and connected to the lift. DON indicated that based on the interviews from staff, staff were not positioned appropriately during the transfer. DON stated the lift and sling were removed from the floor and immediately inspected by maintenance. DON stated maintenance reported a bolt loose on the cradle of the Hoyer and there was a rubber sleeve covering the area which was to be in place as well, rubber stoppers were also not in place on the Hoyer cradle hook ends. DON indicated all the other lifts were inspected the same day. DON indicated the NAs involved had not been tested for competency following the incident, and not all staff had received re-education pertaining to the lift safety, however, the education coordinator was going around doing audits and providing the education. DON stated as part of the facility investigation "we verified that the right sling was used." During an observation on 1/6/22, at 9:34 a.m. R1 sat in her wheelchair at a table in a common area. R1 had a swollen area on the back of her head that was approximately 1-2 centimeters in	F 689	actions to ensure that the deficient practice is being corrected and will not recur? Starting on 1/7/22 when the I-J was cited, Facility will audit hoyer use once a day for seven days. Then five times a week for two weeks. Then once a week for 1 month. Facility will audit documentation of service requests on TELS once a week for 1 month. Further Audits will be discussed and monitored during QAPI meetings. The facility was back into compliance on 1/28/22.	

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 01/10/2022

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 689	Continued From page 5	F 689		

diameter and was raised approximately 0.5 centimeters, the surrounding area was observed to have bruising in various stages of healing. NA-A and NA-B stated R1 was cooperative when in the lift and did not have behaviors. NAs indicated resident care plans identified the sling size they were supposed to use. NA-B stated she had worked at the facility for about 7 months, although she had been shown how to use the lift, she was not tested to ensure competency. NA-A indicated an unawareness of the last time she had received education and/or testing to ensure competency. NAs stated they had not received any re-education within the last two weeks pertaining to lift safety.

During an observation on 1/6/22, at 11:01 a.m. the lift and sling that had been removed from the floor was observed with the administration and DON. The size of the sling was identified as a "small" using the color chart on the lift. DON confirmed the size of the sling as small, and that sling had been used in the incident on 12/31/21.

During an observation on 1/6/22, at 12:28 p.m. R1 sat straight in her wheelchair in her room. NA-A and NA-B knocked on R1's door and explained they were going to transfer her to her bed. NAs placed the lift sling underneath R1 as she sat in her wheelchair. R1 was cooperative. NA-A stated the size of the sling was small. NAs hooked the sling loops to the lift, when NA-A pushed the up button on the lift, the lift did not move, the display panel directed to change the battery. NA-A bypassed the warning message by simultaneously pressing the up and down buttons on the lift. R1 was then raised out of her chair, as R1 went up in the air she started leaning to the right side so that her shoulder was not totally

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 01/10/2022

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 689	Continued From page 6	F 689		

supported inside the sling (the sling placement was in the middle of R1's right shoulder.) NA-B stood on R1's right side during the transfer guiding R1 in the sling as NA-B pushed the lift towards the bed. NAs did not stop the transfer to reposition the sling and/or identify the sling was too small for R1.

During an interview on 1/6/22, at 2:08 p.m. NA-F confirmed she was involved in R1's lift transfer that resulted in a fall with injury. NA-F stated she was going to transfer R1 from bed to shower chair, had put the sling underneath R1 in bed, and hooked the sling up to the machine. NA-F stated she then called for assistance from NA-G. NA-F indicated once NA-G was in the room he ran the lift, while she stood at the head of the bed. NA-F indicated NA-G had raised R1 up off the bed, as NA-G pulled the lift out from underneath the bed, R1 started to sway, R1 started to lean to left, then suddenly her top half rolled out of the sling. NA-F stated she thought R1's sling was too small because it did not go around her shoulders. NA-F stated DON provided immediate education verbally after the event, had not completed an assigned training module and indicated she had not been audited for competency since the event.

During an interview on 1/6/22, at 2:26 p.m. NA-G confirmed he was involved in R1's lift transfer that resulted in a fall. NA-G stated NA-F called for assistance for R1's transfer. NA-G stated ,"I opened the door she [NA-F] was lifting her [R1] up." NA-G indicated NA-F had started moving the lift underneath the bed, R1 started to sway as the lift moved out from under the bed, R1 started leaning left and suddenly rolled out of the sling. NA-G stated her upper body was on the floor and

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 01/10/2022

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 689	Continued From page 7	F 689		

her feet were still in the sling. NA-G stated it happened so quick he could not get to her in time. NA-G stated R1 used a small lift sling, "It doesn't wrap around her shoulders, it doesn't seem big enough." NA-G indicated the DON had provided verbal education, had not been audited, and was assigned a learning module, however, had not yet completed it.

After the IJ was called, the facility completed a comprehensive safe transfer assessment dated 1/7/22 that identified R1 required a medium sized sling for transfers and not a small.

R6
R6's care plan for transfers dated 8/24/21, did not identify the size of sling R6 required for safe transfers. The care plan included, "Hoyer assist x2." R6's care plan was revised on 1/6/22, indicated R6 required a medium sling, however, the record did not include an assessment that identified how the medium sling size was determined to be appropriate and safe for R6.

R6's progress note dated 9/26/21, at 11:53 a.m. included, "Resident had a near miss fall. Two CNA's [certified nursing assistants] were transferring resident from bed to chair using a hoyer lift when the left upper strap came undone. CNA's stated they lowered him to the floor, and resident hit his left shoulder on the hoyer lift leg. CNA's witnessed he did not hit his head. Resident is claiming he did. Assessed for any injuries. No injuries noted."

R6's fall care plan dated 9/27/21, included, "9/26/21-Fall during Hoyer transfer, hit left shoulder. NP [nurse practitioner] provided orders for x-rays, education to staff per DON [director of

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 01/10/2022

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 689	Continued From page 8	F 689		

nursing] via 5-minute meeting to review and sign stating A2 mechanical lift transfers must have 2nd person verifying that resident's [sic] is appropriately and safely secure in lift prior to transfer and to ensure slings and straps are correctly positioned. Maintenance to do a safety check on all mechanical lifts and slings."

R6's quarterly MDS dated 12/18/21, indicated R6 had moderate cognitive impairment and did not have behaviors. The MDS identified R6 required assistance from two or more staff for transfers.

Facility's Monthly Preventative Maintenance (PM) records were reviewed from September through December 2021. The PM checklist directed to complete wheel inspection and cleaning. Completed forms reviewed from September to December 2021, the forms identified the month in which inspections had been completed but not the date. The forms indicated wheel preventative maintenance had been completed for the month, however, did not identify when the 9/18/21, request for wheel cleaning had been specifically completed.

During an interview on 1/7/22, at 3:45 p.m. DON stated the incident was considered a near miss as R6 was lowered to the floor by staff. DON indicated staff visualized a sling loop slipping off the lift. DON indicated after the incident she had provided education of the requirement for having two staff for Hoyer transfers, appropriately attaching sling to lift, and verification of placement. DON stated she had also watched and/or participated in transfers, however, had stopped documenting on 10/11/21. DON indicated she had not assessed residents to ensure proper sling size for residents after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 01/10/2022

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 689	Continued From page 9 incident. During an interview on 1/9/2022, NA-E stated she had been the second person in the room when the incident happened. NA-E indicated she entered the room and R6's sling had already been connected to the lift by the other NA who was in the room. NA-E stated as R6 was raised into the air, she saw the one sling loop came undone, causing R6 to lean outside the sling. NA-E stated they manually lowered R6 to the floor, and in the process R6 bumped his shoulder on one of the Hoyer legs. NA-E stated, "I think the one loop was not latched all the way, I should have made sure the loop was in all the way and verified it." NA-E stated the sling that was used was a medium. During an interview on 1/10/22, at 9:35 a.m. director of maintenance (DM) indicated mechanical lift inspections were completed monthly in accordance with manufacturer's recommendations. DM stated if something was identified during the monthly inspections then it was recorded on the preventative maintenance form. DM indicated direct floor staff were supposed to alert maintenance if there was a concern with the lift and remove it from service. DM indicated if a service request was communicated between monthly checks the issue and fix were not recorded. During an interview on 1/10/22, at 11:11 a.m. DON indicated after the event she had requested for maintenance to look at the lift, however, there was no documentation that had been completed. DON referenced the historical orders on her computer and stated on 9/18/21, she had submitted a high priority ticket; "All the EZ stands	F 689		

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 01/10/2022

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 689	Continued From page 10	F 689		

and Hoyers have hair around the wheels and they are getting hard to push resident on them. Please clean the wheels." DON stated according to the tracking system, the order was set to in-progress on 9/18/21, and as of 9/30/21, the documentation does not indicate this was completed.

After the IJ was identified, the facility completed a comprehensive safe transfer assessment dated 1/7/22, that identified R6 required a large sized sling for transfers and not a medium.

R2
R2's care plan for transfers dated 8/4/21, included, "The resident requires mechanical lift with (2) staff assistance for transfers"; the care plan did not identify R2's sling size. The care plan revised on 1/6/22, directed staff to use large sling.

R2's quarterly MDS dated 11/11/21, indicated R1 had diagnoses that included multiple sclerosis and did not have cognitive impairment. The MDS indicated R1 required assistance from two or more staff for transfers.

R2's record did not include an assessment that identified how the large sling size was determined to be appropriate and safe for R2.

During an observation on 1/6/21, at 11:21 a.m. NA-C walked out of R2's room carrying a lift sling. NA-C stated the sling was an extra large (XL) and was too big for R2 and she was going to get the right size. NA-C indicated the wrong sized sling had not been used today, however, had been used a few times to transfer because R2's sling was in the wash. At 11:23 a.m. R2 stated she had been using a sling that was too large because hers was in the wash. R2 stated staff had only

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 01/10/2022

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 689	Continued From page 11	F 689		

transferred her a couple of times using the XL sling. NA-C and NA-D then safely transferred R2 out of her bed to her wheelchair using the correct size sling.

After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected large sling was appropriate for R2.

R3
R3's significant change MDS dated 10/28/21, identified R3 had diagnoses that included dementia and Alzheimer's disease, was assessed by staff to have severe cognitive impairment, had signs and symptoms of delirium that were continuously present, and had physical behaviors. The MDS indicated R3 required assistance of two or more staff for transfers.

R3's care plan for transfers dated 12/13/21, did not identify a sling size for R6. The care plan included the resident is totally dependent on two staff with Hoyer lift for transfers. She is to have a full body sling used for transfers and it is to stay under her while in her Broda chair.

After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected medium full body sling was appropriate for R3.

R4
R4's transfer care plan dated 10/19/21, did not identify a sling size for R4. The care plan included; the resident requires a mechanical lift (Hoyer) with 2 staff assistance for transfers. The revised transfer care plan dated 1/6/22, directed staff to use an extra-large sling.

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 01/10/2022

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 689	Continued From page 12 R4's quarterly MDS dated 10/25/21, indicated R4 did not have cognitive impairment and did not have behaviors. The MDS identified R4 required two or more staff assistance for transfers. After the IJ was identified the facility completed a comprehensive safe transfer assessment on 1/7/22, that reflected that the extra-large sling was appropriate for R4. R5 R5's quarterly MDS dated 10/23/21, indicated R5 had severe cognitive impairment and did not have behaviors. The MDS identified R5 required assistance of two or more staff for transfers. R5's transfer care plan dated 12/19/2019, indicated R5 required two staff assistance with Hoyer lift and used a small sling size. R5's record did not include an assessment that identified how the small sling size was determined to be appropriate and safe for R5. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that identified R5 required a medium size sling for transfers and not a small. R7 R7's admission MDS dated 12/18/21, identified R7 had diagnoses that included seizure or epilepsy disorders. The MDS indicated R7 had moderate cognitive impairment with signs and symptoms of delirium that fluctuated, and did not have behaviors. The MDS indicated R7 required extensive assistance from two or more staff members for transfers.	F 689		

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 01/10/2022

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 689	Continued From page 13 R7's Baseline Care Plan for transfers revised on 1/6/22, indicated R7 was a pivot transfer, however, was moved to a Hoyer on 1/6/22, related to decline in condition. The care plan included, "Transfer: A2 Hoyer- medium sling." R7's record lacked a comprehensive assessment that identified how the medium sling size was determined to be appropriate and safe for R7. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected the medium sling was appropriate for R7. R8 R8's significant change MDS dated 10/16/21, identified R8 had diagnoses that included dementia and anxiety disorder. The MDS indicated R8 had severe cognitive impairment with fluctuating symptoms of delirium and had verbal behaviors directed at others. The MDS also identified R8 required assistance of two or more staff for transfers. R8's care plan for transfers dated 10/25/21, identified R8 required a Hoyer lift with two staff assistance; the care plan did not identify a sling size. R8's care plan revised on 1/6/22, included the aforementioned level of assistance and directed staff to use a small sling. R8's record lacked a comprehensive assessment that identified how the small sling was determined to be appropriate and safe for R8. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22, that identified R8 required a medium size	F 689		

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 01/10/2022

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 689	Continued From page 14 sling for transfers and not a small. R9 R9's care plan for transfers dated 11/16/20, indicated R9 required assistance from two staff with Hoyer and a large sling. R9's quarterly MDS dated 10/11/21, identified R9 had diagnoses that included dementia, Alzheimer's disease, and Parkinson's. The MDS indicated R9 had moderate cognitive impairment and had behaviors that were not directed toward others. The MDS also identified R9 required two or more staff assistance for transfers. R9's record lacked a comprehensive assessment that identified how the large sling size was determined to be appropriate and safe for R9. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22, that reflected the large sling was appropriate for R9. During an interview on 1/6/22, at 3:08 p.m. education coordinator (EC) stated the lift sheet needed to encompass the shoulders to keep balance, if NAs thought the sling was not fitting appropriately, they should report to the nurse. EC stated she had been out of the facility when the event occurred and had started providing verbal education to remaining staff pertaining to requirement of having 2nd person in the room, proper positioning of the sling, proper placement of lift straps onto the lift, and instructions to provide to residents during transfers on 1/3/22, when she had returned to work. EC indicated not all staff had been provided education and seven regularly scheduled staff were left. EC stated she	F 689		

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 01/10/2022

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 689	Continued From page 15 had not completed audits on staff to ensure competency since the incident on 12/31/21. EC indicated upon hire staff were assigned to learning modules pertaining to mechanical lifts and then were supposed to be competency tested. EC indicated training then is provided annually and as needed. EC indicated after April 2021 competency testing upon new hire orientation was not always completed and there were a few staff who did not receive the training. EC stated she was in the process of doing that now. Review of the facility's training records identified new hires completed the manufacturer's video for the lifts however, testing to ensure competency with safe transfer techniques were not completed for 13 of 13 staff members who were hired after 4/21/21. During an interview on 1/7/22, at 9:31 a.m. licensed practical nurse (LPN)-A stated sling sizes were assessed by therapy or nursing evaluations. LPN-A indicated nurse managers were responsible for assessing and care planning the correct sling size. LPN-A indicated the proper sling size is important to prevent falls and injury. During an interview on 1/7/22, at 10:27 a.m. NA-H indicated R1 was cooperative during transfers and had a tendency to start leaning to her right side when she got tired. NA-H stated she has not been at the facility very long. NA-H stated her training for mechanical lifts included watching videos and watching facility staff. NA-H stated she had not been tested for competency and was going to complete with the education coordinator on 1/10/22.	F 689		

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 01/10/2022

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 689	Continued From page 16 The immediate jeopardy was removed on 1/10/22, at 12:50 p.m. after verification the facility had implemented an acceptable plan of correction that included: 1) Facility developed a safe transfer assessment and provided training on the assessment tool. 2) Comprehensive assessment for sling size were completed for all residents who required mechanical lift for transfers. 2) Care plans for residents who required mechanical lift transfers were updated to reflect appropriate sling size per the comprehensive assessment. 3) All staff were provided with education and competency testing was completed. EZ Way Lift Manufacturer Operator's Instructions included the following: -For safe operation of EZ Way Smart Lift, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients. WARNING: For safe operation of the EZ Way Smart Lift, the lift must be used by trained personnel in accordance with the operator's manual, video and training checklist to avoid injury to patient. -As patients do vary in size, shape, weight, and temperament, these conditions must be taken into consideration when deciding which EZ Way sling is suitable for each patient's needs. NOTE! The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of the patient. **It is important that no portion of the patient overlap the sides of the sling. -When the battery level becomes low swap the battery with a fully charged battery. NOTE: if the	F 689		

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 01/10/2022

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 689	Continued From page 17 battery indicator reads "SWAP BATTERY", the lift will go down but not up. -Competency checklist included the following: Demonstrate proper fitting of sling to the resident, demonstrate proper attachment of sling to lift, and Demonstrate how and when to change battery. -All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. Facility policy Ecumen Resident Lift Purchase Policy dated 1/31/2019, included "Communities are required to log and track all preventative maintenance and emergency services in TELS"	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: KFKN11

Dear Administrator:

The above facility was surveyed on January 6, 2022 through January 10, 2022 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 64900
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
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/6/22 through 1/10/22, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: (MN00079842 and MN00079815) with a licensing order issued at 0830. 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 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete comprehensive safe transfer assessments for 9 of 9 residents (R1, R2, R3, R4, R5, R6, R7, R8, and R9), ensure the appropriate sling size was used for safe transfer for 4 of 9 residents (R1, R6, R5, and R8), develop a consistent system for repair of mechanical lifts, and failed to assess staff competency to ensure safe transfers via full body mechanical lifts. The facility's failures	2 830	Corrected	1/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 resulted in actual falls with injury for 2 of 9 residents (R1, R6) and immediate jeopardy (IJ) situation for (R1). The immediate jeopardy began on 12/31/21, when R1 had a fall from the mechanical lift that resulted in a head strike and a hospital transfer after staff involved in the mechanical lift transfer did not follow manufacturer's recommendations for safe transfers and the facility failed to assess staff were competent to use equipment safely. The administrator and director of nursing were notified of the immediate jeopardy at 12:00 p.m. on 1/7/22. The immediate jeopardy was removed on 1/10/22, but non-compliance remained at scope and severity of E scope and severity level pattern which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1 R1's care plan for transfers dated 7/12/21, included, "The resident requires A2 [assist of 2] Hoyer transfers." and did not identify the size of sling appropriate for R1. The care plan for transfer revised on 1/5/22 included, "The resident requires A2 [assist of two] Hoyer transfers. Ensure proper sized sling is used, proper placement of sling straps and that Hoyer is functioning properly." The care plan did not identify the size of the sling. R1's care plan revised on 1/6/22, included the aforementioned however, directed staff to use a small sling. R1's quarterly Minimum Data Set (MDS) dated 10/18/21, identified that R1 had diagnoses that included dementia and R1's cognition was severely impaired. The MDS indicated R1 did not	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 have verbal, physical, and rejection of care behaviors. The MDS also indicated R1 required assistance of two or more staff for transfers. R1's progress note dated 12/31/21, at 5:50 p.m. included, "Nurse called to residents' room at 3:10 p.m. by aide, and found resident lying in bed on her back with blood area under her head. She was awake. Aide stated she fell and hit her head on the right hoyer base. Nurse lifted head slightly to see swollen area to back center of head and a dark red spot about 4 inches wide with lighter color surrounding it. Nurse left to call 911 about 3:15 p.m." The note indicated R1 was transferred to the hospital around 3:45 p.m. and the nurse was informed by emergency room nurse that R1 would be discharged back to the facility with no stitches needed. A subsequent progress note at 8:51 p.m. indicated R1 had returned to the facility at 8:45 p.m.. Facility reported incident dated 12/31/21 at 4:27 p.m. indicated at 3:25 p.m. on 12/31/21, two staff were assisting R1 using a Hoyer (full body mechanical lift) to transfer R1 to the shower chair when the upper left side of the transfer sling slipped from Hoyer and R1 fell towards the ground hitting her head on the leg of the Hoyer. R1 was transferred to the hospital for further evaluation; R1 sustained a bump to the back of her head with a laceration. R1's record lacked evidence of a comprehensive assessment for sling size in accordance with manufacturer's recommendations for safe transfers. During the entrance conference on 1/6/22, at 9:15 a.m. with the director of nursing (DON) and administrator the DON provided a recapitulation	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 of R1's fall from the lift and the facility's investigation and interventions to date. DON stated she immediately received the call from the nurse and immediately began her investigation. DON indicated based on interviews, R1 was being lifted off the bed, the sling started swaying, R1 leaned to the left, R1's upper body then rolled out of the sling which caused R1's head strike on the leg of the lift. DON indicated the head strike resulted in a hematoma to the back of her head with a small laceration and was transferred to hospital for further evaluation and returned later that evening with no new orders. DON indicated the interviews were inconsistent in that nursing assistant (NA)-F stated both aides were in the room at the time of the transfer, however, NA-G stated he was just entering the room as NA-F was lifting R1 off the bed and could not get to R1 before she rolled out of the sling. DON stated she immediately provided both aides verbal education on responsibilities of 2nd person during transfers and verification of the sling loops connected to the lift. DON stated it is required 2 staff are present during hoyer transfers; the second person checks to ensure the sling is positioned correctly and connected to the lift. DON indicated that based on the interviews from staff, staff were not positioned appropriately during the transfer. DON stated the lift and sling were removed from the floor and immediately inspected by maintenance. DON stated maintenance reported a bolt loose on the cradle of the Hoyer and there was a rubber sleeve covering the area which was to be in place as well, rubber stoppers were also not in place on the Hoyer cradle hook ends. DON indicated all the other lifts were inspected the same day. DON indicated the NAs involved had not been tested for competency following the incident, and not all staff had received re-education pertaining to the lift safety, however,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 the education coordinator was going around doing audits and providing the education. DON stated as part of the facility investigation "we verified that the right sling was used." During an observation on 1/6/22, at 9:34 a.m. R1 sat in her wheelchair at a table in a common area. R1 had a swollen area on the back of her head that was approximately 1-2 centimeters in diameter and was raised approximately 0.5 centimeters, the surrounding area was observed to have bruising in various stages of healing. NA-A and NA-B stated R1 was cooperative when in the lift and did not have behaviors. NAs indicated resident care plans identified the sling size they were supposed to use. NA-B stated she had worked at the facility for about 7 months, although she had been shown how to use the lift, she was not tested to ensure competency. NA-A indicated an unawareness of the last time she had received education and/or testing to ensure competency. NAs stated they had not received any re-education within the last two weeks pertaining to lift safety. During an observation on 1/6/22, at 11:01 a.m. the lift and sling that had been removed from the floor was observed with the administration and DON. The size of the sling was identified as a "small" using the color chart on the lift. DON confirmed the size of the sling as small, and that sling had been used in the incident on 12/31/21. During an observation on 1/6/22, at 12:28 p.m. R1 sat straight in her wheelchair in her room. NA-A and NA-B knocked on R1's door and explained they were going to transfer her to her bed. NAs placed the lift sling underneath R1 as she sat in her wheelchair. R1 was cooperative. NA-A stated the size of the sling was small. NAs	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 hooked the sling loops to the lift, when NA-A pushed the up button on the lift, the lift did not move, the display panel directed to change the battery. NA-A bypassed the warning message by simultaneously pressing the up and down buttons on the lift. R1 was then raised out of her chair, as R1 went up in the air she started leaning to the right side so that her shoulder was not totally supported inside the sling (the sling placement was in the middle of R1's right shoulder.) NA-B stood on R1's right side during the transfer guiding R1 in the sling as NA-B pushed the lift towards the bed. NAs did not stop the transfer to reposition the sling and/or identify the sling was too small for R1. During an interview on 1/6/22, at 2:08 p.m. NA-F confirmed she was involved in R1's lift transfer that resulted in a fall with injury. NA-F stated she was going to transfer R1 from bed to shower chair, had put the sling underneath R1 in bed, and hooked the sling up to the machine. NA-F stated she then called for assistance from NA-G. NA-F indicated once NA-G was in the room he ran the lift, while she stood at the head of the bed. NA-F indicated NA-G had raised R1 up off the bed, as NA-G pulled the lift out from underneath the bed, R1 started to sway, R1 started to lean to left, then suddenly her top half rolled out of the sling. NA-F stated she thought R1's sling was too small because it did not go around her shoulders. NA-F stated DON provided immediate education verbally after the event, had not completed an assigned training module and indicated she had not been audited for competency since the event. During an interview on 1/6/22, at 2:26 p.m. NA-G confirmed he was involved in R1's lift transfer that resulted in a fall. NA-G stated NA-F called for	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8	2 830		

assistance for R1's transfer. NA-G stated ,"I opened the door she [NA-F] was lifting her [R1] up." NA-G indicated NA-F had started moving the lift underneath the bed, R1 started to sway as the lift moved out from under the bed, R1 started leaning left and suddenly rolled out of the sling. NA-G stated her upper body was on the floor and her feet were still in the sling. NA-G stated it happened so quick he could not get to her in time. NA-G stated R1 used a small lift sling, "It doesn't wrap around her shoulders, it doesn't seem big enough." NA-G indicated the DON had provided verbal education, had not been audited, and was assigned a learning module, however, had not yet completed it.

After the IJ was called, the facility completed a comprehensive safe transfer assessment dated 1/7/22 that identified R1 required a medium sized sling for transfers and not a small.

R6
R6's care plan for transfers dated 8/24/21, did not identify the size of sling R6 required for safe transfers. The care plan included, "Hoyer assist x2." R6's care plan was revised on 1/6/22, indicated R6 required a medium sling, however, the record did not include an assessment that identified how the medium sling size was determined to be appropriate and safe for R6.

R6's progress note dated 9/26/21, at 11:53 a.m. included, "Resident had a near miss fall. Two CNA's [certified nursing assistants] were transferring resident from bed to chair using a hoyer lift when the left upper strap came undone. CNA's stated they lowered him to the floor, and resident hit his left shoulder on the hoyer lift leg. CNA's witnessed he did not hit his head. Resident is claiming he did. Assessed for any injuries. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 injuries noted." R6's fall care plan dated 9/27/21, included, "9/26/21-Fall during Hoyer transfer, hit left shoulder. NP [nurse practitioner] provided orders for x-rays, education to staff per DON [director of nursing] via 5-minute meeting to review and sign stating A2 mechanical lift transfers must have 2nd person verifying that resident's [sic] is appropriately and safely secure in lift prior to transfer and to ensure slings and straps are correctly positioned. Maintenance to do a safety check on all mechanical lifts and slings." R6's quarterly MDS dated 12/18/21, indicated R6 had moderate cognitive impairment and did not have behaviors. The MDS identified R6 required assistance from two or more staff for transfers. Facility's Monthly Preventative Maintenance (PM) records were reviewed from September through December 2021. The PM checklist directed to complete wheel inspection and cleaning. Completed forms reviewed from September to December 2021, the forms identified the month in which inspections had been completed but not the date. The forms indicated wheel preventative maintenance had been completed for the month, however, did not identify when the 9/18/21, request for wheel cleaning had been specifically completed. During an interview on 1/7/22, at 3:45 p.m. DON stated the incident was considered a near miss as R6 was lowered to the floor by staff. DON indicated staff visualized a sling loop slipping off the lift. DON indicated after the incident she had provided education of the requirement for having two staff for Hoyer transfers, appropriately attaching sling to lift, and verification of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 placement. DON stated she had also watched and/or participated in transfers, however, had stopped documenting on 10/11/21. DON indicated she had not assessed residents to ensure proper sling size for residents after the incident. During an interview on 1/9/2022, NA-E stated she had been the second person in the room when the incident happened. NA-E indicated she entered the room and R6's sling had already been connected to the lift by the other NA who was in the room. NA-E stated as R6 was raised into the air, she saw the one sling loop came undone, causing R6 to lean outside the sling. NA-E stated they manually lowered R6 to the floor, and in the process R6 bumped his shoulder on one of the Hoyer legs. NA-E stated, "I think the one loop was not latched all the way, I should have made sure the loop was in all the way and verified it." NA-E stated the sling that was used was a medium. During an interview on 1/10/22, at 9:35 a.m. director of maintenance (DM) indicated mechanical lift inspections were completed monthly in accordance with manufacturer's recommendations. DM stated if something was identified during the monthly inspections then it was recorded on the preventative maintenance form. DM indicated direct floor staff were supposed to alert maintenance if there was a concern with the lift and remove it from service. DM indicated if a service request was communicated between monthly checks the issue and fix were not recorded. During an interview on 1/10/22, at 11:11 a.m. DON indicated after the event she had requested for maintenance to look at the lift, however, there	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 was no documentation that had been completed. DON referenced the historical orders on her computer and stated on 9/18/21, she had submitted a high priority ticket; "All the EZ stands and Hoyers have hair around the wheels and they are getting hard to push resident on them. Please clean the wheels." DON stated according to the tracking system, the order was set to in-progress on 9/18/21, and as of 9/30/21, the documentation does not indicate this was completed. After the IJ was identified, the facility completed a comprehensive safe transfer assessment dated 1/7/22, that identified R6 required a large sized sling for transfers and not a medium. R2 R2's care plan for transfers dated 8/4/21, included, "The resident requires mechanical lift with (2) staff assistance for transfers"; the care plan did not identify R2's sling size. The care plan revised on 1/6/22, directed staff to use large sling. R2's quarterly MDS dated 11/11/21, indicated R1 had diagnoses that included multiple sclerosis and did not have cognitive impairment. The MDS indicated R1 required assistance from two or more staff for transfers. R2's record did not include an assessment that identified how the large sling size was determined to be appropriate and safe for R2. During an observation on 1/6/21, at 11:21 a.m. NA-C walked out of R2's room carrying a lift sling. NA-C stated the sling was an extra large (XL) and was too big for R2 and she was going to get the right size. NA-C indicated the wrong sized sling had not been used today, however, had been used a few times to transfer because R2's sling	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 was in the wash. At 11:23 a.m. R2 stated she had been using a sling that was too large because hers was in the wash. R2 stated staff had only transferred her a couple of times using the XL sling. NA-C and NA-D then safely transferred R2 out of her bed to her wheelchair using the correct size sling. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected large sling was appropriate for R2. R3 R3's significant change MDS dated 10/28/21, identified R3 had diagnoses that included dementia and Alzheimer's disease, was assessed by staff to have severe cognitive impairment, had signs and symptoms of delirium that were continuously present, and had physical behaviors. The MDS indicated R3 required assistance of two or more staff for transfers. R3's care plan for transfers dated 12/13/21, did not identify a sling size for R6. The care plan included the resident is totally dependent on two staff with Hoyer lift for transfers. She is to have a full body sling used for transfers and it is to stay under her while in her Broda chair. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected medium full body sling was appropriate for R3. R4 R4's transfer care plan dated 10/19/21, did not identify a sling size for R4. The care plan included; the resident requires a mechanical lift (Hoyer) with 2 staff assistance for transfers. The	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 revised transfer care plan dated 1/6/22, directed staff to use an extra-large sling. R4's quarterly MDS dated 10/25/21, indicated R4 did not have cognitive impairment and did not have behaviors. The MDS identified R4 required two or more staff assistance for transfers. After the IJ was identified the facility completed a comprehensive safe transfer assessment on 1/7/22, that reflected that the extra-large sling was appropriate for R4. R5 R5's quarterly MDS dated 10/23/21, indicated R5 had severe cognitive impairment and did not have behaviors. The MDS identified R5 required assistance of two or more staff for transfers. R5's transfer care plan dated 12/19/2019, indicated R5 required two staff assistance with Hoyer lift and used a small sling size. R5's record did not include an assessment that identified how the small sling size was determined to be appropriate and safe for R5. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that identified R5 required a medium size sling for transfers and not a small. R7 R7's admission MDS dated 12/18/21, identified R7 had diagnoses that included seizure or epilepsy disorders. The MDS indicated R7 had moderate cognitive impairment with signs and symptoms of delirium that fluctuated, and did not have behaviors. The MDS indicated R7 required extensive assistance from two or more staff	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 members for transfers. R7's Baseline Care Plan for transfers revised on 1/6/22, indicated R7 was a pivot transfer, however, was moved to a Hoyer on 1/6/22, related to decline in condition. The care plan included, "Transfer: A2 Hoyer- medium sling." R7's record lacked a comprehensive assessment that identified how the medium sling size was determined to be appropriate and safe for R7. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22 that reflected the medium sling was appropriate for R7. R8 R8's significant change MDS dated 10/16/21, identified R8 had diagnoses that included dementia and anxiety disorder. The MDS indicated R8 had severe cognitive impairment with fluctuating symptoms of delirium and had verbal behaviors directed at others. The MDS also identified R8 required assistance of two or more staff for transfers. R8's care plan for transfers dated 10/25/21, identified R8 required a Hoyer lift with two staff assistance; the care plan did not identify a sling size. R8's care plan revised on 1/6/22, included the aforementioned level of assistance and directed staff to use a small sling. R8's record lacked a comprehensive assessment that identified how the small sling was determined to be appropriate and safe for R8. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22, that identified R8 required a medium size	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 sling for transfers and not a small. R9 R9's care plan for transfers dated 11/16/20, indicated R9 required assistance from two staff with Hoyer and a large sling. R9's quarterly MDS dated 10/11/21, identified R9 had diagnoses that included dementia, Alzheimer's disease, and Parkinson's. The MDS indicated R9 had moderate cognitive impairment and had behaviors that were not directed toward others. The MDS also identified R9 required two or more staff assistance for transfers. R9's record lacked a comprehensive assessment that identified how the large sling size was determined to be appropriate and safe for R9. After the IJ was identified, the facility completed a comprehensive safe transfer assessment on 1/7/22, that reflected the large sling was appropriate for R9. During an interview on 1/6/22, at 3:08 p.m. education coordinator (EC) stated the lift sheet needed to encompass the shoulders to keep balance, if NAs thought the sling was not fitting appropriately, they should report to the nurse. EC stated she had been out of the facility when the event occurred and had started providing verbal education to remaining staff pertaining to requirement of having 2nd person in the room, proper positioning of the sling, proper placement of lift straps onto the lift, and instructions to provide to residents during transfers on 1/3/22, when she had returned to work. EC indicated not all staff had been provided education and seven regularly scheduled staff were left. EC stated she had not completed audits on staff to ensure	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 competency since the incident on 12/31/21. EC indicated upon hire staff were assigned to learning modules pertaining to mechanical lifts and then were supposed to be competency tested. EC indicated training then is provided annually and as needed. EC indicated after April 2021 competency testing upon new hire orientation was not always completed and there were a few staff who did not receive the training. EC stated she was in the process of doing that now. Review of the facility's training records identified new hires completed the manufacturer's video for the lifts however, testing to ensure competency with safe transfer techniques were not completed for 13 of 13 staff members who were hired after 4/21/21. During an interview on 1/7/22, at 9:31 a.m. licensed practical nurse (LPN)-A stated sling sizes were assessed by therapy or nursing evaluations. LPN-A indicated nurse managers were responsible for assessing and care planning the correct sling size. LPN-A indicated the proper sling size is important to prevent falls and injury. During an interview on 1/7/22, at 10:27 a.m. NA-H indicated R1 was cooperative during transfers and had a tendency to start leaning to her right side when she got tired. NA-H stated she has not been at the facility very long. NA-H stated her training for mechanical lifts included watching videos and watching facility staff. NA-H stated she had not been tested for competency and was going to complete with the education coordinator on 1/10/22. The immediate jeopardy was removed on 1/10/22, at 12:50 p.m. after verification the facility	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 had implemented an acceptable plan of correction that included: 1) Facility developed a safe transfer assessment and provided training on the assessment tool. 2) Comprehensive assessment for sling size were completed for all residents who required mechanical lift for transfers. 2) Care plans for residents who required mechanical lift transfers were updated to reflect appropriate sling size per the comprehensive assessment. 3) All staff were provided with education and competency testing was completed. EZ Way Lift Manufacturer Operator's Instructions included the following: -For safe operation of EZ Way Smart Lift, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients. WARNING: For safe operation of the EZ Way Smart Lift, the lift must be used by trained personnel in accordance with the operator's manual, video and training checklist to avoid injury to patient. -As patients do vary in size, shape, weight, and temperament, these conditions must be taken into consideration when deciding which EZ Way sling is suitable for each patient's needs. NOTE! The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of the patient. **It is important that no portion of the patient overlap the sides of the sling. -When the battery level becomes low swap the battery with a fully charged battery. NOTE: if the battery indicator reads "SWAP BATTERY", the lift will go down but not up. -Competency checklist included the following:	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00394	A. BUILDING: _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARKS LIVING	400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 Demonstrate proper fitting of sling to the resident, demonstrate proper attachment of sling to lift, and Demonstrate how and when to change battery. -All EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided. Facility policy Ecumen Resident Lift Purchase Policy dated 1/31/2019, included "Communities are required to log and track all preventative maintenance and emergency services in TELS" SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to mechanical lift safety, to assure proper assessment and safety modalities in accordance with manufacturer's recommendations are being implemented. They could develop and implement an orientation program in addition to an ongoing education program for mechanical lift competency. The DON/designee could then develop and implement system for evaluating and monitoring consistent implementation of these policies with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		