

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

M. Prig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



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

M. Ping

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

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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

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 02/17/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION 5		E SURVEY PLETED
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		243369	D. WING			01/	10/2022
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F 000	INITIAL COMMENT	rs	FC	000)		
	On 1/6/22 through	1/10/22, a standard					
		was completed at your facility					
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		ith requirements of 42 CFR					
		B, the requirements for Long					
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	Terrir Gare Facilities	3.					
	The following comp	laints were found to be					
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		deficiencies cited at F689.					
	William (19019)	deliciencies cited at 1 009.					
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		ad a fall from the mechanical					
		head strike and a hospital					
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	transfer did not follo						
		or safe transfers and the					
		ess staff were competent to					
		ely. The immediate jeopardy					
	removed on 1/7/22.	and the immediacy was					
	removed on 1/1/22.						
	The above findings	constituted substandard					
		constituted substandard an extended survey was					
	conducted from 1/7	122 IU 1/ IU/22.					
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		of compliance upon the					
	Department's accer	otance. Because you are					
		olance. Because you are our signature is not required					
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	be used as verificat	поп от сотприансе.					
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		ur facility may be conducted to					
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LABORATOR\	L / DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		ntial compliance with the attained in accordance with				
	Free of Accident Ha CFR(s): 483.25(d)(azards/Supervision/Devices 1)(2)	F 689			1/28/22
	()()					
	supervision and assaccidents.	resident receives adequate sistance devices to prevent				
	Based on observat review, the facility fa comprehensive safe of 9 residents (R1,	ion, interview, and document ailed to complete e transfer assessments for 9 R2, R3, R4, R5, R6, R7, R8, e appropriate sling size was		How will Corrective action be accomplished for those residents for have been affected by the deficient practice?	ound to	
	used for safe transf R6, R5, and R8), de repair of mechanica staff competency to body mechanical lif resulted in actual fa	fer for 4 of 9 residents (R1, evelop a consistent system for al lifts, and failed to assess o ensure safe transfers via full ts. The facility's failures alls with injury for 2 of 9 and immediate jeopardy (IJ)		Facility implemented a new sling size assessment tool on 1/7/22. Nurse Managers were trained by DON on the new assess tool. In addition all residents were assessed for correct hoyer sling size in the event a hoyen eeded for that resident. Staff meminvolved with	ment er is	
	when R1 had a fall resulted in a head s after staff involved i did not follow manu for safe transfers a staff were compete	pardy began on 12/31/21, from the mechanical lift that strike and a hospital transfer in the mechanical lift transfer facturer's recommendations and the facility failed to assess to use equipment safely.		the hoyer incident were immediatel verbally trained by DON. Residents assessed on 1/7/22 for proper sling size. Carwere adjusted to include appropriat sizing on 1/7/22. Care sheets were also updainclude appropriate size so direct c	e plans te ated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 689	notified of the imme on 1/7/22. The immon 1/10/22, but non scope and severity pattern which indica potential for more timmediate jeopardy. Findings include: R1 R1's care plan for tincluded, "The resid Hoyer transfers." as ling appropriate for transfer revised on requires A2 [assist Ensure proper size placement of sling functioning properly identify the size of trevised on 1/6/22, i however, directed servised on 1/6/22, i however, directed servised on 1/6/22, i however, directed servised on 1/6/21, identified included dementia severely impaired. have verbal, physic behaviors. The MD assistance of two of R1's progress note included, "Nurse cap.m. by aide, and for her back with blood was awake. Aide ston the right hoyer before the service of the service of the pack with blood was awake. Aide ston the right hoyer before the service of the pack with blood was awake. Aide ston the right hoyer before the service of the pack with blood was awake. Aide ston the right hoyer before the service of the pack with blood was awake. Aide ston the right hoyer before the service of the pack with blood was awake. Aide ston the right hoyer before the pack with blood was awake. Aide ston the right hoyer before the pack with blood was awake. Aide ston the right hoyer before the pack with blood was awake.	ediate jeopardy at 12:00 p.m. nediate jeopardy was removed n-compliance remained at of E scope and severity level ated no actual harm with han minimal harm that is not	F 689	staff would be aware of proper sling to a 1/7/22. Facility removed the hoyer involved in incident from service on 12/31/2 comprehensive assessment of lift conducted to determine proper functioning. All Nurses, TMA's, and were re-trained and competency tested on hoyer us to starting their next shift. New hoy slings have been purchased and receive Ez-Way Inc. to ensure enough qua proper size for each resident. How will the facility identify other re having the potential to be affected same deficient practice? All residents were assessed using new sling size assessment tool on Adjustments have been made to th plans and care sheets to identify th correct sling size for each resident requirin hoyer lift. All lifts were inspected of 12/31/21 to ensure proper functioning. What measures will be put into pla systemic changes made, to ensure the deficient practice will not recur? Facility implemented a new sling s assessment tool on 1/7/22 that will	lift 1 until a was d CNA's see prior rer d from untity of sesidents by the the 1/7/22. see care see see see see see see see see see s	

AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING C 245369 B. WING 01/10/2022		
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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 he head strike resulted in a hematoma to the back of he head strike resulted in a hematoma to the back of he head strike resulted in a hematoma to the back of he head strike resulted in a hematoma to the back of he head strike resulted in a hematoma to the back of he head strike resulted in a hematom at the back of he head strike resulted in a hematoma to the back of he head strike resulted in a hematom at the back of he he	dark red spot color surround 3:15 p.m." The to the hospital was informed would be disclusitiches needed 8:51 p.m. indicated were assisting mechanical lift when the upper slipped from Higround hitting R1 was transfevaluation; R1 her head with R1's record late assessment for manufacturer' transfers. During the ental a.m. with the cadministrator of R1's fall from investigation as stated she immonurse and immonute in the leg of the	

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with a small laceration ar hospital for further evaluation that evening with no new the interviews were incorrected he was just entering was lifting R1 off the bed before she rolled out of the immediately provided before she rolled out of the lift. DON stated it is represent during hoyer transperson checks to ensure correctly and connected that based on the intervien not positioned appropriation DON stated the lift and sithe floor and immediately maintenance. DON state a bolt loose on the cradle was a rubber sleeve cover to be in place as well, rut not in place on the Hoyer indicated all the other lifts same day. DON indicated not been tested for compincident, and not all staff re-education pertaining to the education coordinato doing audits and providin stated as part of the facil verified that the right sline.	and was transferred to justion and returned later w orders. DON indicated onsistent in that nursing both aides were in the transfer, however, NA-Gring the room as NA-F d and could not get to R1 the sling. DON stated she oth aides verbal education d person during transfers ing loops connected to required 2 staff are insfers; the second e the sling is positioned to the lift. DON indicated lews from staff, staff were ately during the transfer. In sling were removed from ly inspected by ed maintenance reported le of the Hoyer and there wering the area which was abber stoppers were also ber cradle hook ends. DON its were inspected the ed the NAs involved had petency following the f had received to the lift safety, however, or was going around ing the education. DON illity investigation "we may was used."		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 Facility will audit hoyer use once a seven days. Then five times a week two weeks. Then once a week for month. Facility will audit documentation of service requests on TELS once a week for month. Further Audits will be discussed and monite during QAPI meetings. The facility was back into complian 1/28/22.	s cited, day for k for I 1	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 00 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912	0.0	10/2022
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F 689	centimeters, the su to have bruising in NA-A and NA-B sta in the lift and did not indicated resident of size they were supphad worked at the falthough she had be she was not tested indicated an unawahad received education was re-education with pertaining to lift safe. During an observation the lift and sling that floor was observed DON. The size of the "small" using the confirmed the size of the sling had been used. During an observation was observed DON. The size of the sling had been used. During an observation was observed bed. The size of the sling had been used. During an observation was observed bed. NA-B known and NA-B k	aised approximately 0.5 rrounding area was observed various stages of healing. ted R1 was cooperative when of have behaviors. NAs eare plans identified the sling cosed to use. NA-B stated she facility for about 7 months, een shown how to use the lift, to ensure competency. NA-A reness of the last time she ation and/or testing to ensure stated they had not received ithin the last two weeks	F6	689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) DROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		245369	B. WING				C 10/2022
	PROVIDER OR SUPPLIER KS LIVING			400 - 15TH	DDRESS, CITY, STATE, ZIP CODE AVENUE SOUTHWEST MN 55912	, <u></u>	10,2022
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F 689	supported inside the was in the middle of stood on R1's right guiding R1 in the slitowards the bed. Note that resulted in a fawas going to transfect that resulted once and hooked the slir stated she than the lift of the slir R1's sling was too so around her shoulded immediate education to completed an a indicated she had recompetency since to the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall. Not assistance for R1's opened the door should be was in resulted in a fall of the fal	e sling (the sling placement f R1's right shoulder.) NA-B side during the transfer ing as NA-B pushed the lift As did not stop the transfer to and/or identify the sling was on 1/6/22, at 2:08 p.m. NA-F involved in R1's lift transfer ll with injury. NA-F stated she er R1 from bed to shower ling underneath R1 in bed, ag up to the machine. NA-F led for assistance from NA-G. e NA-G was in the room he e stood at the head of the d NA-G had raised R1 up off ulled the lift out from I, R1 started to sway, R1 ft, then suddenly her top half leg. NA-F stated she thought small because it did not go ars. NA-F stated DON provided on verbally after the event, had ssigned training module and not been audited for		689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	her feet were still in happened so quick time. NA-G stated I doesn't wrap aroun seem big enough." provided verbal edu and was assigned a had not yet comple After the IJ was cal comprehensive saf 1/7/22 that identifies sling for transfers at R6 R6's care plan for tridentify the size of stransfers. The care x2." R6's care plan indicated R6 require the record did not in identified how the nodetermined to be a R6's progress note included, "Resident CNA's [certified nur transferring resident hoyer lift when the I CNA's stated they I resident hit his left state CNA's witnessed he is claiming he did. A injuries noted."	the sling. NA-G stated it he could not get to her in R1 used a small lift sling, "It d her shoulders, it doesn't NA-G indicated the DON had acation, had not been audited, a learning module, however, ted it. led, the facility completed a e transfer assessment dated d R1 required a medium sized and not a small. ransfers dated 8/24/21, did not sling R6 required for safe plan included, "Hoyer assist was revised on 1/6/22, ed a medium sling, however, anclude an assessment that medium sling size was appropriate and safe for R6. dated 9/26/21, at 11:53 a.m. a had a near miss fall. Two resing assistants] were at from bed to chair using a left upper strap came undone. If owered him to the floor, and shoulder on the hoyer lift leg. It is did not hit his head. Resident Assessed for any injuries. No	F 6	889			
	shoulder. NP [nurse	Hoyer transfer, hit left practitioner] provided orders n to staff per DON [director of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	DING	CON	COMPLETED	
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F 689	nursing] via 5-minut stating A2 mechanic person verifying that appropriately and stransfer and to ensicorrectly positioned check on all mechanic had moderate cognitive behaviors. The assistance from two Facility's Monthly Precords were review December 2021. The completed forms reduced behaviors and the date. The forms maintenance had behaviored in the date. The forms maintenance had behaviored for wheel of completed. During an interview stated the incident was R6 was lowered indicated staff visual the lift. DON indicated provided education two staff for Hoyer that and/or participated stopped documentic staff or staff or staff or participated stopped documentic staff or	te meeting to review and sign cal lift transfers must have 2nd at resident's [sic] is afely secure in lift prior to ure slings and straps are I. Maintenance to do a safety inical lifts and slings." I dated 12/18/21, indicated R6 litive impairment and did not the MDS identified R6 required to or more staff for transfers. I reventative Maintenance (PM) where PM checklist directed to pection and cleaning. The eviewed from September through the PM checklist directed to pection and cleaning. The eviewed from September to be forms identified the month in the endicated wheel preventative the endicated wheel preventative the endicated wheel preventative the endicated wheel preventative the sindicated wheel preventative the endicated wheel preventative the endicated wheel preventative the endicated wheel preventative the sindicated wheel preventative the endicated wheel preventation th	F	689		
		ot assessed residents to size for residents after the				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED			
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F 689	incident. During an interview had been the second the incident happer entered the room a been connected to was in the room. Note into the air, she saw undone, causing Render, and in the proon one of the Hoyer on one of the Hoyer one loop was not late have made sure the verified it." NA-E stawas a medium. During an interview director of maintenamechanical lift inspersonately in accordance recommendations, identified during the was recorded on the form. DM indicated supposed to alert maintenamechanicated between the composed to the computer and states and dix were not recommendations.	on 1/9/2022, NA-E stated she and person in the room when hed. NA-E indicated she and R6's sling had already the lift by the other NA who A-E stated as R6 was raised with the one sling loop came to to lean outside the sling. It is an ually lowered R6 to the cress R6 bumped his shoulder right legs. NA-E stated, "I think the triched all the way, I should be loop was in all the way and atted the sling that was used atted the sling that was used and the sling that was used be monthly inspections then it is preventative maintenance direct floor staff were maintenance if there was a stand remove it from service. Ervice request was ween monthly checks the issue were monthly checks the issue in the preventative maintenance.		589			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ·		LE CONSTRUCTION	COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	and Hoyers have have are getting hard to clean the wheels." I tracking system, the on 9/18/21, and as does not indicate the After the IJ was ide comprehensive saft 1/7/22, that identifies sling for transfers at R2 R2's care plan for transfers at with (2) staff assistate plan did not identify revised on 1/6/22, or R2's quarterly MDS had diagnoses that and did not have contact the stage of the	air around the wheels and they push resident on them. Please DON stated according to the e order was set to in-progress of 9/30/21, the documentation his was completed. Intified, the facility completed a e transfer assessment dated at R6 required a large sized and not a medium. Interpretation of the progress of 9/30/21, the documentation his was completed. Intified, the facility completed a e transfer assessment dated at R6 required a large sized and not a medium. Interpretation of the progress of the care plan directed staff to use large sling. Indicated 11/11/21, indicated R1 included multiple sclerosis ognitive impairment. The MDS and assistance from two or	F	689			
	identified how the late to be appropriate and During an observation NA-C walked out of NA-C stated the sling was too big for R2 aright size. NA-C indicated and not been used used a few times to was in the wash. At been using a sling to the size was in the wash.	include an assessment that arge sling size was determined and safe for R2. ion on 1/6/21, at 11:21 a.m. FR2's room carrying a lift sling. Ing was an extra large (XL) and and she was going to get the licated the wrong sized sling today, however, had been transfer because R2's sling 11:23 a.m. R2 stated she had that was too large because sh. R2 stated staff had only					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y41) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ING		COMPLETED	
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F 689	transferred her a cosling. NA-C and NA out of her bed to he size sling. After the IJ was ide comprehensive saft 1/7/22 that reflected for R2. R3 R3's significant chaidentified R3 had downertia and Alzheby staff to have seven signs and symptom continuously prese. The MDS indicated or more staff for transfer with Hoyer lift full body sling used under her while in MAfter the IJ was ide comprehensive saft 1/7/22 that reflected appropriate for R3. R4 R4's transfer care pidentify a sling size included; the reside (Hoyer) with 2 staff (Hoyer) with 2 sta	couple of times using the XL A-D then safely transferred R2 er wheelchair using the correct entified, the facility completed a fe transfer assessment on d large sling was appropriate ange MDS dated 10/28/21, iagnoses that included eimer's disease, was assessed are cognitive impairment, had as of delirium that were nt, and had physical behaviors. I R3 required assistance of two ansfers. Transfers dated 12/13/21, did size for R6. The care plan and is totally dependent on two for transfers. She is to have a later transfer and it is to stay the merchant of the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a fe transfer assessment on defined in the facility completed a feet transfer assessment on defined in the facility completed a feet transfer assessment on defined in the facility completed a feet transfer assessment on defined in the facility completed a feet transfer assessment on defined in the facility completed and the facilit	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 689	Continued From pa	ge 12	F6	889			
	did not have cogniti have behaviors. Th	dated 10/25/21, indicated R4 ive impairment and did not e MDS identified R4 required ssistance for transfers.					
	comprehensive safe	ntified the facility completed a e transfer assessment on d that the extra-large sling R4.					
	had severe cognitive behaviors. The MD	dated 10/23/21, indicated R5 re impairment and did not have S identified R5 required r more staff for transfers.					
		olan dated 12/19/2019, ed two staff assistance with a small sling size.					
	identified how the s	include an assessment that mall sling size was opropriate and safe for R5.					
	comprehensive safe	ntified, the facility completed a e transfer assessment on d R5 required a medium size nd not a small.					
	R7 had diagnoses to epilepsy disorders. moderate cognitive symptoms of delirium have behaviors. The	eS dated 12/18/21, identified that included seizure or The MDS indicated R7 had impairment with signs and Im that fluctuated, and did not e MDS indicated R7 required the from two or more staff fers.					

AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING	(X3) DATE SURVEY COMPLETED	
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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 assistance of two or more staff for transfers. 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		

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F 689	sling for transfers a R9 R9's care plan for trindicated R9 require with Hoyer and a la R9's quarterly MDS had diagnoses that Alzheimer's disease indicated R9 had m and had behaviors others. The MDS al or more staff assist R9's record lacked that identified how t determined to be ap After the IJ was ide comprehensive saft 1/7/22, that reflecte appropriate for R9. During an interview education coordinat needed to encompa balance, if NAs thos appropriately, they stated she had bee event occurred and education to remain requirement of havi proper positioning of of lift straps onto th provide to residents when she had retur all staff had been p	ransfers dated 11/16/20, ed assistance from two staff rge sling. dated 10/11/21, identified R9 included dementia, e, and Parkinson's. The MDS oderate cognitive impairment that were not directed toward iso identified R9 required two	F	889			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
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F 689	had not completed competency since to indicated upon hire learning modules pand then were suppressed. EC indicated annually and as need 2021 competency to orientation was not were a few staff wheeled EC stated she was now. Review of the facility new hires completed the lifts however, the with safe transfer the for 13 of 13 staff med 4/21/21. During an interview licensed practical in sizes were assessed evaluations. LPN-A were responsible for the correct sling size sling size is importated buring an interview NA-H indicated R1 transfers and had an her right side when she has not been a stated her training for watching videos an stated she had not	audits on staff to ensure he incident on 12/31/21. EC staff were assigned to ertaining to mechanical lifts bosed to be competency d training then is provided eded. EC indicated after April esting upon new hire always completed and there o did not receive the training. in the process of doing that by's training records identified d the manufacturer's video for sting to ensure competency echniques were not completed embers who were hired after on 1/7/22, at 9:31 a.m. urse (LPN)-A stated sling and by therapy or nursing indicated nurse managers or assessing and care planning e. LPN-A indicated the proper ent to prevent falls and injury. In 1/7/22, at 10:27 a.m. was cooperative during a tendency to start leaning to she got tired. NA-H stated the facility very long. NA-H for mechanical lifts included d watching facility staff. NA-H been tested for competency omplete with the education	F	689			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED			
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F 689	The immediate jeon 1/10/22, at 12:50 p. had implemented a correction that including 1) Facility develope and provided training 2) Comprehensive were completed for mechanical lift for the 2) Care plans for remechanical lift transappropriate sling sizes assessment. 3) All staff were procompetency testing EZ Way Lift Manufaincluded the following-For safe operation operators should withrough this manual checklist, and practice used by trained the operator's manuchecklist to avoid in the operator's manufaction of the EZ be used by trained the operator's manufaction of the EZ be used by trained the operator's manufaction of the EZ be used by trained the operator's manufaction of the EZ be used by trained the operator's manufaction of the size/weight desestimates and basic depend on factors of measurements, incompatient. **It is in patient overlap the the the battery I	pardy was removed on m. after verification the facility in acceptable plan of ided: d a safe transfer assessment ag on the assessment tool. assessment for sling size all residents who required ransfers. sidents who required ansfers were updated to reflect are per the comprehensive vided with education and was completed. acturer Operator's Instructions ag: of EZ Way Smart Lift, atch the training video, read I, complete the competency ice on fellow staff members ients. WARNING: For safe Way Smart Lift, the lift must personnel in accordance with ual, video and training agiury to patient. If in size, shape, weight, and the conditions must be taken when deciding which EZ Way each patient's needs. NOTE! signations are merely a guidelines. A proper fit will other than weight luding the height and girth of aportant that no portion of the	F	689					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED		
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F 689	battery indicator rea will go down but not -Competency check Demonstrate proped demonstrate proped Demonstrate how a -All EZ Way equipmeregularly by competend maintenance check Facility policy Ecume Policy dated 1/31/20 are required to log a	ads "SWAP BATTERY", the lift tup. klist included the following: r fitting of sling to the resident, r attachment of sling to lift, and and when to change battery. The ment must be maintained tent staff according to the	F	89				



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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.

· 12-6

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		C	
		00394	B. WING		01/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the mumber and MN Ruwhen a rule contain comply with any of lack of compliance.	nether a violation has been				
	result in the assess	ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y	TS: 1/10/22, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				

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

Electronically Signed

(X6) DATE TITLE 01/31/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74101 2741	or contraction	IBENTI TO/CTION NOMBERS.	A. BUILDING:			
		00394	B. WING		C 01/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ST MARK	S LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	O Continued From page 1		2 000			
	The following comp SUBSTANTIATED: MN00079815) with 0830. The Minnesota Dep documenting the St Orders using Feder have been assigned statutes/rules for Notag number appears "ID Prefix Tag." The compliance is listed of Deficiencies" color Comply" portion of the column also include violation of the state "This Rule is not me the surveyor's find Method of Correction. You have agreed to receipt of State lices the Minnesota Department of Heal you electronically. It is necessary for State necessary for State necessary for State lices the word "COI available for text. You electronic State lices heading completion be corrected prior to the Minnesota Department of Department of Department of Heal you electronic State lices heading completion be corrected prior to the Minnesota Department of Department of Department of Department of Heal you electronic State lices heading completion be corrected prior to the Minnesota Department of Depa	laint was found to be (MN00079842 and n a licensing order issued at partment of Health is pate Licensing Correction ral software. Tag numbers d to Minnesota state pursing Homes. The assigned is in the far-left column entitled the state statute/rule out of in the "Summary Statement tumn and replaces the "To the correction order. This test the findings which are in the statute after the statement, the statute after the statement, the tas evidence by." Following ings are the Suggested on and Time Period for the participate in the electronic insure orders consistent with	2 000			

Minnesota Department of Health

STATE FORM 6899 KFKN11 If continuation sheet 2 of 19

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMP	LETED
		00394	B. WING		C 01/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	not required at the l state form.	pottom of the first page of				
	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.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			1/28/22
	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.					
	by: Based on observati review, the facility fa comprehensive safe of 9 residents (R1, I and R9), ensure the used for safe transf R6, R5, and R8), de repair of mechanica staff competency to	ent is not met as evidenced on, interview, and document ailed to complete e transfer assessments for 9 R2, R3, R4, R5, R6, R7, R8, e appropriate sling size was fer for 4 of 9 residents (R1, evelop a consistent system for al lifts, and failed to assess o ensure safe transfers via full ts. The facility's failures		Corrected		

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00394	B. WING		C 01/10/2022	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/1	OIZOZZ
ST MARKS LIVING			HAVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	resulted in actual faresidents (R1, R6) situation for (R1). The immediate jeop when R1 had a fall resulted in a head safter staff involved idid not follow manufor safe transfers as staff were compete. The administrator anotified of the immediate on 1/7/22. The immon 1/7/22, but non scope and severity pattern which indicate potential for more the immediate jeopardy. Findings include: R1 R1's care plan for the included, "The residential for more the included, "The resident plans in the residence of the included of the immediate jeopardy. The residence of the included	and immediate jeopardy (IJ) pardy began on 12/31/21, from the mechanical lift that strike and a hospital transfer in the mechanical lift transfer in the mechanical lift transfer if acturer's recommendations and the facility failed to assess ant to use equipment safely, and director of nursing were ediate jeopardy at 12:00 p.m. arediate jeopardy was removed accompliance remained at a of E scope and severity level ated no actual harm with than minimal harm that is not and did not identify the size of a R1. The care plan for a 1/5/22 included, "The resident of two] Hoyer transfers. A sling is used, proper straps and that Hoyer is a and that Hoyer is a and the sling. R1's care plan ancluded the aforementioned staff to use a small sling.	2 830			
	10/18/21, identified included dementia	num Data Set (MDS) dated that R1 had diagnoses that and R1's cognition was The MDS indicated R1 did not				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING:			
		00394	B. WING		C 01/10/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	have verbal, physic behaviors. The MD assistance of two of R1's progress note included, "Nurse cap.m. by aide, and for her back with blood was awake. Aide stoon the right hoyer beto see swollen areadark red spot about color surrounding it 3:15 p.m." The note to the hospital arou was informed by enwould be discharge stitches needed. A 8:51 p.m. indicated at 8:45 p.m Facility reported incop.m. indicated at 3:3 were assisting R1 umechanical lift) to the when the upper left slipped from Hoyer ground hitting her hR1 was transferred evaluation; R1 sust her head with a lace R1's record lacked assessment for slin manufacturer's record transfers.	al, and rejection of care S also indicated R1 required r more staff for transfers. dated 12/31/21, at 5:50 p.m. alled to residents' room at 3:10 bund resident lying in bed on a area under her head. She sated she fell and hit her head ase. Nurse lifted head slightly at to back center of head and a at 4 inches wide with lighter. Nurse left to call 911 about a indicated R1 was transferred and 3:45 p.m. and the nurse hergency room nurse that R1 and back to the facility with no subsequent progress note at R1 had returned to the facility sident dated 12/31/21 at 4:27 at 25 p.m. on 12/31/21, two staff using a Hoyer (full body ransfer R1 to the shower chair side of the transfer sling and R1 fell towards the lead on the leg of the Hoyer. To the hospital for further ained a bump to the back of	2 830			
		or of nursing (DON) and ON provided a recapitulation				

Minnesota Department of Health

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iviinnesc	ta Department of He	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						`
		00394	B. WING			0/2022
		00334			01/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	(A D/D) A	400 - 15Ti	HAVENUE S	OUTHWEST		
SIMARI	KS LIVING	AUSTIN, I	MN 55912			
()(4) ID	CLIMMA DV CTA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 830	Continued From pa	nge 5	2 830			
2 000	Continued From pa	ige 3	2 000			
	of R1's fall from the	e lift and the facility's				
	investigation and in	terventions to date. DON				
	stated she immedia	ately received the call from the				
	nurse and immedia	itely began her investigation.				
	DON indicated bas	ed on interviews, R1 was				
	being lifted off the b	ped, the sling started swaying,				
	R1 leaned to the le	ft, R1's upper body then rolled				
	out of the sling which	ch caused R1's head strike on				
	the leg of the lift. D	ON indicated the head strike				
	resulted in a hemat	toma to the back of her head				
	with a small lacerat	tion and was transferred to				
	hospital for further	evaluation and returned later				
	that evening with no	o new orders. DON indicated				
	the interviews were	inconsistent in that nursing				
	assistant (NA)-F sta	ated 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 th	e bed and could not get to R1				
	before she rolled or	ut of the sling. DON stated she				
	immediately provide	ed both aides verbal education				
	on responsibilities	of 2nd person during transfers				
	and verification of t	he sling loops connected to				
	the lift. DON stated	it is required 2 staff are				
	present during hoye	er transfers; the second				
	person checks to e	nsure the sling is positioned				
		ected to the lift. DON indicated				
	that based on the ir	nterviews from staff, staff were				
	not positioned appr	opriately during the transfer.				
	DON stated the lift	and sling were removed from				
	the floor and immed	diately inspected by				
	maintenance. DON	stated maintenance reported				
		cradle of the Hoyer and there				
		e covering the area which was				
		ell, rubber stoppers were also				
		Hoyer cradle hook ends. DON				
	indicated all the oth	ner lifts were inspected the				
	same day. DON inc	dicated the NAs involved had				
		competency following the				
	incident, and not al	I staff had received				
		ning to the lift safety, however,				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00394	B. WING			C 1 0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING		H AVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	the education coord doing audits and prostated as part of the verified that the right at in her wheelchat area. R1 had a swoth head that was appropriate to have bruising in NA-A and NA-B states in the lift and did not indicated resident of size they were supplied worked at the falthough she had be she was not tested indicated an unaway had received education with the lift and sling that floor was observed DON. The size of the "small" using the coonfirmed the size of the sling had been used During an observation of the size of the sling had been used During an observation of the size of the sling had been used bed. NAs placed the she sat in her wheeleds.	dinator was going around oviding the education. DON a facility investigation "we at sling was used." ion on 1/6/22, at 9:34 a.m. R1 ir at a table in a common of the area on the back of her oximately 1-2 centimeters in aised approximately 0.5 rounding area was observed various stages of healing. It are the action and to the sling bosed to use. NA-B stated she acility for about 7 months, een shown how to use the lift, to ensure competency. NA-A reness of the last time she atton and/or testing to ensure stated they had not received thin the last two weeks	2 830			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00394	B. WING		01/1	, 0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING	400 - 15Th AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	pushed the up buttomove, the display property is a positive move, and the property is a positive move move. The property is a positive move move move move move move move mo	ops to the lift, when NA-A on on the lift, the lift did not anel directed to change the seed the warning message by sing the up and down buttons hen raised out of her chair, as ir she started leaning to the er shoulder was not totally e sling (the sling placement f R1's right shoulder.) NA-B side during the transfer ing as NA-B pushed the lift As did not stop the transfer to and/or identify the sling was on 1/6/22, at 2:08 p.m. NA-F involved in R1's lift transfer II with injury. NA-F stated she er R1 from bed to shower ling underneath R1 in bed, ag up to the machine. NA-F led for assistance from NA-G. In the led of the did NA-G had raised R1 up off ulled the lift out from II, R1 started to sway, R1 ft, then suddenly her top half ag. NA-F stated she thought small because it did not go are. NA-F stated DON provided on verbally after the event, had ssigned training module and not been audited for the event.	2 830			
		nvolved in R1's lift transfer that A-G stated NA-F called for				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPL	
	00394	B. WING		01/1) 0/2022
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/1	0/2022
ST MARKS LIVING	400 - 15TH	I AVENUE S	OUTHWEST		
2,000	AUSTIN, N		DDG///DEDIG DI AN OF GODDEGT/	ONL	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
opened the door she up." NA-G indicated lift underneath the be lift moved out from u leaning left and sudd NA-G stated her upp her feet were still in thappened so quick hime. NA-G stated Ridoesn't wrap around seem big enough." No provided verbal educand was assigned a had not yet complete. After the IJ was called comprehensive safe 1/7/22 that identified sling for transfers and R6 R6's care plan for transfers. The care pix2." R6's care plan windicated R6 required the record did not included the record did not included the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included, "Resident hime determined to be applied to the record did not included hime determined to be applied to the record did not included hime determined to be applied to the record did not included hime determined to be applied to the record did not included hime determined hime determined hime determined hime determined hime determined hime dete	ransfer. NA-G stated ,"I e [NA-F] was lifting her [R1] NA-F had started moving the ed, R1 started to sway as the inder the bed, R1 started denly rolled out of the sling. Der body was on the floor and the sling. NA-G stated it he could not get to her in 1 used a small lift sling, "It her shoulders, it doesn't NA-G indicated the DON had cation, had not been audited, learning module, however, ed it. ed, the facility completed a transfer assessment dated R1 required a medium sized and not a small. ansfers dated 8/24/21, did not ing R6 required for safe blan included, "Hoyer assist vas revised on 1/6/22, d a medium sling, however, clude an assessment that edium sling size was propriate and safe for R6. dated 9/26/21, at 11:53 a.m. had a near miss fall. Two	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00394	B. WING		01/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	injuries noted."					
	R6's fall care plan of "9/26/21-Fall during shoulder. NP [nurse for x-rays, education nursing] via 5-minu stating A2 mechani person verifying the appropriately and stransfer and to ensicorrectly positioned check on all mechal R6's quarterly MDS had moderate cogniave behaviors. The assistance from two Facility's Monthly Precords were review December 2021. The completed forms reduced forms red	dated 9/27/21, included, g Hoyer transfer, hit left e practitioner] provided orders in to staff per DON [director of the meeting to review and signical lift transfers must have 2nd at resident's [sic] is afely secure in lift prior to the ure slings and straps are at l. Maintenance to do a safety shical lifts and slings." Is dated 12/18/21, indicated R6 intive impairment and did not the MDS identified R6 required to or more staff for transfers. In the reventative Maintenance (PM) wed from September through the PM checklist directed to the pection and cleaning. The eviewed from September to the forms identified the month in the deen completed but not is indicated wheel preventative the een completed for the month, the entify when the 9/18/21, the entify when the enti				

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STATE FORM 6899 KFKN11 If continuation sheet 10 of 19

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 - 15TH AVENUE SOUTHWEST AUSTIN, MN 55912 (X4) ID PREFIX TAG 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X3) DATE SURVEY COMPLETED	E CONSTRUCTION
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) 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	00394	B. WING	_	
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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	placement. DON stated she had also wa and/or participated in transfers, however stopped documenting on 10/11/21. DON indicated she had not assessed resident ensure proper sling size for residents aft incident. During an interview on 1/9/2022, NA-E shad been the second person in the room the incident happened. NA-E indicated sentered the room and R6's sling had alrebeen connected to the lift by the other Naws in the room. NA-E stated as R6 was into the air, she saw the one sling loop of undone, causing R6 to lean outside the NA-E stated they manually lowered R6 to floor, and in the process R6 bumped his on one of the Hoyer legs. NA-E stated, "one loop was not latched all the way, I sl have made sure the loop was in all the way werified it." NA-E stated the sling that wa was a medium. During an interview on 1/10/22, at 9:35 a director of maintenance (DM) indicated mechanical lift inspections were completed monthly in accordance with manufacture recommendations. DM stated if something identified during the monthly inspections was recorded on the preventative mainter form. DM indicated direct floor staff were supposed to alert maintenance if there we concern with the lift and remove it from so DM indicated if a service request was communicated between monthly checks and fix were not recorded. During an interview on 1/10/22, at 11:11 DON indicated after the event she had recorded.	atched r, had N ts to ter the stated she n when she eady A who s raised same sling. o the shoulder I think the hould vay and is used a.m. ted er's ng was then it enance evas a service. s the issue a.m. equested		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, ii B 0 12 B 11 (0 .			
		00394	B. WING		01/1	0/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST MAR	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was no documentar DON referenced the computer and states submitted a high present and Hoyers have he are getting hard to clean the wheels." It tracking system, the on 9/18/21, and as does not indicate the After the IJ was idecomprehensive saf 1/7/22, that identifies sling for transfers at R2 R2's care plan for transfers at R2 R2's care plan for transfers at with (2) staff assistated plan did not identify revised on 1/6/22, or R2's quarterly MDS had diagnoses that and did not have condicated R1 requirements at the properties of the properties of the properties at the properties of the properties at the properties of the properties of the properties of the properties of the properties at the properties of t	tion that had been completed. e historical orders on her ed on 9/18/21, she had itority ticket; "All the EZ stands air around the wheels and they push resident on them. Please DON stated according to the e order was set to in-progress of 9/30/21, the documentation his was completed. Intified, the facility completed a e transfer assessment dated and not a medium. Transfers dated 8/4/21, dent requires mechanical lift ance for transfers"; the care of R2's sling size. The care plan directed staff to use large sling. Included multiple sclerosis organitive impairment. The MDS ed assistance from two or fers. Include an assessment that arge sling size was determined	2 830			

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00394	B. WING		01/1	0/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/1	0/2022
ST MAR	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was in the wash. At been using a sling thers was in the was transferred her a cosling. NA-C and NA out of her bed to he size sling. After the IJ was ide comprehensive saft 1/7/22 that reflected for R2. R3 R3's significant chaidentified R3 had didentified R3 had didementia and Alzheby staff to have sevings and symptom continuously presenthe MDS indicated or more staff for transitional the residential staff with Hoyer lift full body sling used under her while in halfer the IJ was ide comprehensive saft 1/7/22 that reflected appropriate for R3. R4 R4's transfer care pridentify a sling size included; the residentify a sling size included the residentif	and that was too large because sh. R2 stated staff had only ouple of times using the XL and then safely transferred R2 or wheelchair using the correct on tified, the facility completed a set transfer assessment on diarge sling was appropriate of large sling was appropriate of discontinuous disco	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00394	B. WING		01/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15Th AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	revised transfer car staff to use an extra	re plan dated 1/6/22, directed a-large sling.				
	did not have cogniti have behaviors. Th	dated 10/25/21, indicated R4 ve impairment and did not e MDS identified R4 required ssistance for transfers.				
	comprehensive safe	ntified the facility completed a e transfer assessment on d that the extra-large sling · R4.				
	had severe cognitive behaviors. The MD	dated 10/23/21, indicated R5 re impairment and did not have S identified R5 required r more staff for transfers.				
		olan dated 12/19/2019, ed two staff assistance with a small sling size.				
	identified how the s	include an assessment that mall sling size was opropriate and safe for R5.				
	comprehensive safe	ntified, the facility completed a e transfer assessment on d R5 required a medium size nd not a small.				
	R7 had diagnoses the epilepsy disorders. It moderate cognitive symptoms of delirium have behaviors. The	eS dated 12/18/21, identified that included seizure or The MDS indicated R7 had impairment with signs and im that fluctuated, and did not e MDS indicated R7 required the form two or more staff				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00004	B. WING			
		00394	B. WING		<u> 01/1</u>	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST MAR	KS LIVING		H AVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	members for transf	ers.				
	1/6/22, indicated R7 however, was move related to decline in included, "Transfer: R7's record lacked that identified how t determined to be appropriate After the IJ was ide comprehensive safet."	Plan for transfers revised on 7 was a pivot transfer, ed to a Hoyer on 1/6/22, condition. The care plan A2 Hoyer- medium sling." a comprehensive assessment the medium sling size was oppropriate and safe for R7. Intified, the facility completed a e transfer assessment on the medium sling was				
	identified R8 had di dementia and anxie indicated R8 had se with fluctuating sym verbal behaviors dir	nge MDS dated 10/16/21, agnoses that included ety disorder. The MDS evere cognitive impairment aptoms of delirium and had rected at others. The MDS equired assistance of two or fers.				
	identified R8 require assistance; the care size. R8's care plan	ransfers dated 10/25/21, ed a Hoyer lift with two staff e plan did not identify a sling a revised on 1/6/22, included l level of assistance and e a small sling.				
		a comprehensive assessment he small sling was determined nd safe for R8.				
	comprehensive safe	ntified, the facility completed a e transfer assessment on ed R8 required a medium size				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00394	B. WING		01/1) 0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST MARI	KS LIVING	400 - 15TH AUSTIN, N		OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	sling for transfers and not a small.					
		ransfers dated 11/16/20, ed assistance from two staff rge sling.				
	had diagnoses that Alzheimer's disease indicated R9 had m and had behaviors	dated 10/11/21, identified R9 included dementia, e, and Parkinson's. The MDS oderate cognitive impairment that were not directed toward so identified R9 required two ance for transfers.				
	that identified how t	a comprehensive assessment he large sling size was opropriate and safe for R9.				
	comprehensive safe	ntified, the facility completed a e transfer assessment on d the large sling was				
	education coordinate needed to encompare balance, if NAs those appropriately, they stated she had bee event occurred and education to remain requirement of having proper positioning of lift straps onto the provide to residents when she had returnall staff had been pregularly scheduled	on 1/6/22, at 3:08 p.m. tor (EC) stated the lift sheet ass the shoulders to keep ught the sling was not fitting should report to the nurse. EC n out of the facility when the had started providing verbalning staff pertaining to ng 2nd person in the room, of the sling, proper placement e lift, and instructions to a during transfers on 1/3/22, ned to work. EC indicated not rovided education and seven a staff were left. EC stated she audits on staff to ensure				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00394	B. WING		01/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING		H AVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	competency since to indicated upon hire learning modules properly and then were suppletested. EC indicated annually and as new 2021 competency to orientation was not were a few staff where EC stated she was now. Review of the facility new hires completed the lifts however, the with safe transfer the for 13 of 13 staff med 4/21/21. During an interview licensed practical in sizes were assessed evaluations. LPN-A were responsible for the correct sling size sling size is importated. During an interview NA-H indicated R1 transfers and had a her right side when she has not been a stated her training for watching videos and stated she had not and was going to coordinator on 1/10. The immediate jeographs in the supplementation of the coordinator on 1/10. The immediate jeographs in the supplementation of the supplementatio	the incident on 12/31/21. EC staff were assigned to ertaining to mechanical lifts bosed to be competency distraining then is provided eded. EC indicated after April esting upon new hire always completed and there of did not receive the training in the process of doing that by's training records identified did the manufacturer's video for sting to ensure competency echniques were not completed embers who were hired after on 1/7/22, at 9:31 a.m. urse (LPN)-A stated sling and by therapy or nursing indicated nurse managers or assessing and care planning e. LPN-A indicated the proper ent to prevent falls and injury. on 1/7/22, at 10:27 a.m. was cooperative during tendency to start leaning to she got tired. NA-H stated the facility very long. NA-H for mechanical lifts included did watching facility staff. NA-H been tested for competency omplete with the education	2 830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00394	B. WING		01/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST MAR	KS LIVING		HAVENUE S MN 55912	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	had implemented a correction that inclu 1) Facility develope and provided trainin 2) Comprehensive a were completed for mechanical lift for tr 2) Care plans for remechanical lift transappropriate sling sizussessment. 3) All staff were procompetency testing EZ Way Lift Manufaincluded the following-For safe operation operators should wathrough this manual checklist, and praction of the EZ be used by trained	n acceptable plan of ided: d a safe transfer assessment in g on the assessment tool. assessment for sling size all residents who required iransfers. sidents who required isfers were updated to reflect ize per the comprehensive invided with education and invasion was completed.	2 830			
	checklist to avoid in -As patients do vary temperament, these into consideration will sling is suitable for The size/weight desestimates and basic depend on factors of measurements, include the patient. **It is impatient overlap the s-When the battery with a fully obattery indicator reasonable.	jury to patient. If in size, shape, weight, and a conditions must be taken when deciding which EZ Way each patient's needs. NOTE! signations are merely a guidelines. A proper fit will other than weight luding the height and girth of apportant that no portion of the sides of the sling. Evel becomes low swap the charged battery. NOTE: if the lift will size in the lift in the sides "SWAP BATTERY", the lift in the sides "SWAP BATTERY", the lift in the sides in the sides in the sides "SWAP BATTERY", the lift in the sides "SWAP BATTERY", the lift in the sides in the sides in the sides "SWAP BATTERY", the lift in the sides "SWAP BATTERY", the lift in the sides in t				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						С	
00394		B. WING		01/1	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	demonstrate proper Demonstrate how a -All EZ Way equipm regularly by compet maintenance check Facility policy Ecum Policy dated 1/31/20 are required to log a maintenance and e SUGGESTED MET The director of nurs review/revise policiem echanical lift safe assessment and sa with manufacturer's implemented. They an orientation program competency. The Edevelop and implementioring consisted policies with the residual brought to the facility Committee for review of the same competency.	r fitting of sling to the resident, r attachment of sling to lift, and and when to change battery. The nent must be maintained tent staff according to the clist provided. The Resident Lift Purchase of 19, included "Communities and track all preventative mergency services in TELS" THOD OF CORRECTION: The of the signer of	2 830				

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