DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

March 18, 2026

Administrator
ST MARKS LIVING
400 15TH AVENUE SOUTHWEST
AUSTIN, MN 55912

RE: CCN: 055842700
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 2, 2026, survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 2, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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(ies) listed below to the CMS location for imposition. The CMS location 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 April 2, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 2, 2026 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 2, 2026 (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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

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 March 2, 2026. 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 September 2, 2026 (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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to 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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which

resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2026

Administrator
ST MARKS LIVING
400 15TH AVENUE SOUTHWEST
AUSTIN, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: 1F170E-H1

Dear Administrator:

The above facility survey was completed on March 2, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 30, 2026

Administrator
ST MARKS LIVING
400 15TH AVENUE SOUTHWEST
AUSTIN, MN 55912

RE: CCN: 245369
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 18, 2026, we informed you of imposed enforcement remedies.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 2, 2026.

- Civil money penalty. (42 CFR 488.430 through 488.444)

On April 10, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. **T**he most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is/are as follows:

F842 - Resident Records - Identifiable Information

In addition, at the time of this revisit, we identified the following new deficiency:

F580 - Notify of Changes (Injury/Decline/Room, Etc.)

As a result of the revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 2, 2026.

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.

As we notified you in our letter of March 18, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 2, 2026.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division 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 September 2, 2026

(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

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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 2/20/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 3/2/2/26 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in immediate jeopardy (IJ) to resident health and safety. An IJ at F689 that began on 2/25/26, when The IJ began when nursing assistant (NA)-C and NA-D had to be stopped from using the wrong harness size according to R4's care plan and the failed to follow manufacturer's instructions to tighten the harness torso strap to ensure safety putting R4 at risk for serious harm/injury or death The administrator and director of nursing (DON) were notified of the IJ on 2/26/26 at 6:08p.m. Immediate jeopardy was removed on 3/2/26 at 2:30 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/27/26 and 3/2/26. The following complaints were reviewed: H53692080C (2699728), H53696441C (2745221 and 2745648) with a deficiencies cited at F689 at IJ, F760, F686, F842, F867. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		03/18/2026
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F0686	F686 Plan of Correction	04/02/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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

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F0686 SS = G	Continued from page 1 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents at risk for or with pressure ulcers received ongoing comprehensive assessment, individualized reassessment of pressure-relief effectiveness, and revised interventions necessary to prevent deterioration and support healing for /3 /of 3 /residents /(R10, R4, R9) reviewed for pressure ulcers. This resulted in actual harm for R10 who had facility acquired stage 2 pressure ulcer on left sacral region (buttock) that deteriorated to a stage 3 pressure ulcer. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds),	F0686	Continued from page 1 1. How the deficiency was corrected for the resident(s) identified Residents R10, R4, and R9 received a comprehensive skin assessment completed by the Director of Nursing on 2/27/2026. Wound characteristics were assessed and documented Treatment orders were reviewed and updated as needed Interventions were reviewed and individualized based on assessment findings Residents with a Braden Scale of 12 and below which indicated high skin injury Care plans were updated to reflect current interventions 2. How other residents having the potential to be affected were identified and what corrective action was taken All residents identified as high risk for skin breakdown received a comprehensive skin assessment on 2/27/2026 All remaining residents received a skin assessment by 3/2/2026 The following were reviewed: Skin integrity status Existing wounds Risk factors Current interventions Any concerns identified: Provider notified of new or worsening skin concerns	

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F0686 SS = G	Continued from page 2 medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R10's face sheet dated 3/3/26, identified diagnoses of multiple sclerosis, diabetes, heart failure, neurogenic bladder and bowel, and chronic kidney disease. R10's quarterly Minimum Data Set (MDS) dated 9/18/25, identified R10 was cognitively intact, no behaviors, no rejection of care, had impairment on both lower extremities, used a wheelchair, dependent to roll left and right, dependent for transfers, at risk for pressure ulcers, had no unhealed pressure ulcers, no venous/arterial ulcers, had moisture associated skin damage (MASD); used pressure reducing device for chair and bed, was not on a turning and repositioning program, had application of non-surgical dressings other than feet; and application of ointments/medications other than feet. R10's Braden Scale for Predicting Pressure Sore Risk dated 9/18/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions to elevate heels off bed, pressure reducing mattress on bed, pressure reducing pad in chair, turn and reposition while in bed. R10's Activity of Daily Living (ADL) focus care plan dated 9/4/21, identified R10 had a self-care deficit related to multiple sclerosis (MS) and MS complications. Goal to be clean and well groomed. Interventions as follows: -Transfers: dependent on two staff (dated 5/14/25). -Bed mobility: dependent on staff for repositioning and	F0686	Continued from page 2 Orders obtained as necessary interventions were updated Turning/repositioning plans were individualized based on the Braden scale and resident mobility Care plans were revised accordingly 3. What systemic changes were made to ensure the deficient practice will not recur The facility implemented the following systemic changes: Individualized turning and repositioning programs are now developed based on: Comprehensive skin assessment Wound status if applicable A standard process for wound monitoring was implemented to ensure: Weekly wound assessments are completed by a registered nurse Measurements, characteristics, and progression are documented in the weekly ulcer/complex wound observation tool A wound escalation process was implemented: Wounds that show no improvement, worsening, or new skin breakdown will be: Reported to the provider Reviewed by wound nurse/DON Evaluated for treatment changes Referred to wound specialist as indicated	

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F0686 SS = G	Continued from page 3 turning in bed (dated 12/16/25). R10's skin integrity focus care plan revision date of 12/16/25, identified R10 had potential/actual impairment to skin integrity with fragile skin related to limited mobility and moisture associated skin damage (MASD). Goal to be free of any skin related infection. Interventions as follows: -Elevate heels off bed (dated 11/24/21). -Skin barrier cream/ointment to protect skin as needed (dated11/24/21). -Pressure reducing pad while in chair (dated 6/21/24). -Have resident lay down one hour every shift to relieve pressure off peri area. Start 4/11/25. -Avoid pulling buttocks open with care and treatment (dated 9/24/25). -Nutrition supplements as ordered for wound healing (dated 9/24/25). -Provide peri care two times per shift on days and evening (dated 9/24/25). -Reposition every hour while in chair (dated 9/24/25). -Turn and reposition while in bed every two hours (dated 9/24/25). Review of R10's Skin Assessments dated 9/19/25, 9/26/25, 10/3/25, 10/10/25, 10/24/25 (completed 14 days after last assessment) identified R10 had redness to bottom/skin breakdown on each of the assessments. R10's assessments did not identify location, measurements, wound type, nor any other wound characteristics. R10's physician orders identified the following: -Wound left buttocks: wash per facility protocol, pat dry, apply zinc oxide (a medical cream to treat skin irritations) ointment twice daily for 14 days; after 14 days apply barrier cream to wound until resolved twice daily. Start date 8/15/25 with end date of 11/19/25. R10's Skin Assessment dated 11/7/25, identified left buttocks had "healing popped blisters." Mepilex (foam dressing) had been applied. No other wound characteristics including measurements, wound integrity, and location on the buttock were included. R10's record did not identify a corresponding physician order for the treatment of the foam dressing. However, physician order dated 11/8/25 directed alternating pressure air mattress; a full 30 degrees turns side to side every 2 hours while in bed; reposition every hour while in bed; cushion to chair -such as ROHO (air filled pressure-relief cushion) when in wheelchair; elevate heels while in bed. R10's Skin Assessment dated 11/14/25, identified a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm. R10's assessment did not identify any description of the wound characteristics. Corresponding progress note included a situation, background,	F0686	Continued from page 3 Licensed nurses received education on: Comprehensive skin assessments Identification of worsening wounds on 3/31/2026 Documentation requirements on 3/26/2026 Individualized interventions 3/26/2026 Competency validation was completed for licensed nurses to ensure ability to: Identification in escalation Implement and monitor interventions General skin integrity concern education 3/31/2026 Wound education will be given by wound specialist nurse on 4/8/2026 Responsibilities were defined: Registered nurses complete assessments and wound monitoring DON/designee reviews assessments and oversees compliance Care plans updated MDS/Designee 4. How the corrective actions will be monitored to ensure the deficient practice will not recur The Director of Nursing/designee will monitor compliance through: All those identified with skin concerns will be audited 1 /week x 4 weeks All those identified with skin concerns identified with skin concerns x 3 months Audits will include:	

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F0686 SS = G	Continued from page 4 assessment, and response (SBAR) had been sent to physician indicating R10 had a stage 2 pressure ulcer on left buttocks that measured 2.0 (cm) x 1.0 cm with partial thickness loss of skin, skin was pink, had a moist wound bed with fragile surrounding skin. No further characteristics was identified. R10's record reviewed 11/14/25 through 11/16/25 did not include an order for wound care treatment for the identified stage 2 pressure ulcer. R10's nurse practitioner note dated 11/17/25, identified R10 had a stage 2 pressure ulcer on her left buttocks that continue to be open despite nursing care. R10 used a ROHO cushion "but unfortunately the ROHO was placed backwards." R10's physician orders /dated 11/17/25, included the following: -Left buttocks wound to wash with wound cleanser, scrub the wound bed, apply Duoderm Signal (a name brand dressing that signals when it is time to be changed) dressing to wound bed, change every 3rd day or as needed if dressing peels off. Start date 11/17/25. -Apply zinc oxide twice daily to skin surrounding left buttocks wound to act as barrier for incontinence. Do not scrub the zinc oxide off but reapply twice a day for incontinence. Start date 11/17/25. R10's Skin Assessments dated 11/21/25, 11/28/25, and 12/5/25, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Braden Scale for Predicting Pressure Sore Risk dated 12/10/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions as follows: -Elevate heels off bed. -Pressure reducing pad while in chair. -Pressure reducing mattress on bed. -Skin barrier cream/ointment to protect skin as needed. -Turn and reposition while in bed every 2 hours. R10's nurse practitioner nursing home visit note dated 12/13/25, included an order to discontinue all prior wound buttocks wound treatments and new order for buttocks wound treatment of zinc barrier cream mixed with collagen powder twice daily and as needed for incontinence. The visit note did not include wound status and/or characteristics. R10's Skin Assessments dated 12/12/25, 12/19/25, 12/26/25, 1/2/26, and 1/9/26, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Skin	F0686	Continued from page 4 Completion of comprehensive skin assessments Accuracy of wound documentation Individualized turning/repositioning plans Evidence of intervention effectiveness Identification and escalation of non-healing or worsening wounds Care plan accuracy and updates Audit results will be reviewed and trended through the QAPI program, and additional interventions will be implemented as needed. 5. 4/2/2026	

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F0686 SS = G	Continued from page 5 Assessments dated 1/17/26 indicated no change to the size of the stage two pressure ulcer on the left buttock since 11/14/25. The assessment identified the stage 2 ulcer with measurements 2.0 cm x 1.0 cm., marked as improving. No other wound characteristics were included. R10's nurse practitioner (NP) note dated 1/21/26, identified R10 was seen for wound care management. R10 had a stage 3 pressure ulcer on left buttocks near the crease. Original size was 1.7 cm x 1.0 cm x 0.2 cm with current size of 2.0 cm x 3.6 cm x 0.1 cm. Edges distinct and epithelization. Wound bed with granulation and epithelization. Minimal serous (clear and watery) drainage. Tender and not odor present. Periwound with blanchable erythema. Identified current physician orders as wash per facility protocol, pat dry, apply foam dressing, change every 3rd day and as needed for rolling/soiling. Do not apply barrier cream with collagen powder to wound. -Zinc powder with collagen powder on other perianal wounds twice daily and as needed. -Do not scrub or wash barrier cream off when soiled. -Encourage repositioning every 2 hours while in bed to offload pressure. -During the day encourage R10 to lay down for at least 60 minutes at a time to offload pressure at least twice daily. If R10 does not want to lay down at least verify R10 is clean and dry and reposition in wheelchair. In review of R10's record between 11/14/25 when the stage 2 pressure ulcer was first identified through 1/21/26 when the NP identified the ulcer had deteriorated to a stage 3 , there was no indication the existing pressure relieving interventions were evaluated for effectiveness, and no new interventions were added . Additionally, R10's record did not include a comprehensive assessment that identified R10's skin tolerance to pressure over time; it could not be ascertained how every two-hour positioning schedule first initiated on 9/24/25 (prior to ulcer development) was appropriate or effective. R10's physician order dated 1/22/26 directed for other sacral wounds apply zinc barrier cream mixed with collagen powder twice daily and as needed. "Do not apply where dressing for left buttocks wound cut". The transcribed order did not direct the application of the foam dressing changed every 3rd day. Review of R10's January and February 2026 TAR included the physician order that had been transcribed without the foam dressing. The TARs indicated R10's wound treatments were completed without using the foam dressing according to transcribed order. R10's Skin Assessment dated 1/23/26, 1/30/26, 2/6/26, 2/13/26, 2/20/26, and 2/27/26 did not identify the correct staging of the ulcer according to the nurse practitioner instead the assessment identified a healing stage 2 pressure ulcer to left buttocks measuring 2.0 cm x 1.0 cm indicating	F0686		

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F0686 SS = G	Continued from page 6 the wound remained the same size since first identified on 11/14/25. The assessment did not include any wound characteristics. In review of R10's record between 11/15/25 through 2/27/26 revealed R10's record did not include weekly comprehensive skin assessments and even though the TAR directed wound monitoring for any wounds for changes was completed (denoted by check marked boxes) and treatments were completed according to orders (denoted by check marked boxes) that were transcribed, there was no documentation of wound status and characteristics. R10's nursing home nurse practitioner note dated 2/28/26, identified R10's pressure injury stage 3 to left sacral region had resolved. During an interview on 3/2/26 at 12:18 p.m., R10 was in her room seated in her wheelchair. R10 explained she had a "sore" on her bottom but believed it was getting better. R10 stated when she was in bed, staff did come in at night to reposition her every 2 hours. R10 explained in the morning once she got up for the day, she spent most of her time in her electric wheelchair that could lean back "this helps me get off my bottom". R10 then used her controls on her wheelchair to lean back in her chair 45-degree angle which although redistributed the amount of weight from R10's bottom did not completely offload all of her weight from her bottom. R10 stated sometimes she could not tell if her bottom was getting sore because of her MS, "this may be why I got a sore on my bottom." R10 further stated staff did not come into her room to give her direction to reposition while in her chair, so she tried to remember to do it herself, but "sometimes forgets". R10's wheelchair had a ROHO cushion on it with the words "FRONT" on the front of the cushion. R10 stated that the aides had put this wording on the front of the cushion, because staff kept putting the cushion in her chair backwards. R10 stated if her cushion was backwards her bottom worse if not placed correctly. R10 was unaware how long ago the wording was added to the cushion. During an interview on 3/2/26 at 12:34 p.m., trained medication aide (TMA)-C stated R10's wheelchair allowed her to reposition herself in her chair if she felt the need to get off her bottom. TMA-C was unaware R10 was supposed to be repositioned every hour in her chair and was not sure if staff were supposed to remind R10 to reposition in her chair. During an interview on 3/2/26 at 12:38 p.m., nursing assistant (NA)-D stated was she responsible for caring for R10 today but was unaware R10 was supposed to lay down in bed for one hour and was unaware R10 needed to be repositioned every hour while in her wheelchair. NA-D stated once R10 was in her recliner she would notify staff when she wanted to be checked and changed. During the day R10 spent the majority of the time in her wheelchair and did not like to lay	F0686		

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F0686 SS = G	Continued from page 7 in her bed. R10's electric wheelchair reclined to different positions which R10 would do that herself, however, staff did not track how often R10 repositioned. NA-D was not able to articulate how R10's chair was able to take pressure off her bottom. NA-D further explained R10's the chair reclining would not be considered "offloading" her bottom; R10 would have to be completely off her bottom. During an interview on 3/2/26 at 12:40 p.m., licensed practical nurse (LPN)-C stated R10's left buttocks wound had not had an order for a foam dressing since 1/21/26, the wound has been treated with mixing collagen powder with zinc oxide twice a day even though the physician order directed the use of one. LPN-C explained this order should have been clarified with the nurse practitioner before it had been removed off of the orders. LPN-C indicated even though the treatment order was not followed, R10's wound had been healing. During an interview on 3/2/26 at 3:07 p.m., registered nurse manager (RN-NM) stated R10's pressure ulcer on her left sacral region was facility acquired and developed on 11/14/25. RN-NM reviewed R10's skin assessments from 1/22/26 through 2/27/26 and believed the assessments were inaccurate with measurements since R10's left buttocks pressure ulcer as healed on 2/28/26. RN-NM also identified R10's weekly skin assessments were not considered comprehensive. RN-NM was unaware the pressure ulcer was first identified as a stage 2 pressure ulcer and then had deteriorated to a stage 3 pressure ulcer. RN-NM stated R10 was supposed to be turned and repositioned every 2 hours in bed and every hour in her wheelchair "R10 has MS and is not able to feel when she may be having buttocks pain" RN-NM was now aware that direct care staff were relying on R10 to reposition herself when she was in her wheelchair. RN-NM explained R10's every 2-hour turning and repositioning was given as an order by the nurse practitioner; RN-NM was not aware if the frequency was appropriate or effective. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated she was unaware R10's pressure ulcer on her left buttocks had deteriorated to a stage 3 pressure ulcer on 1/21/26. R10's wound staging should have been identified as stage 3 since 1/21/26 remained at stage 3 until the wound had been determined it had healed. On 3/2/26 at 1:05 p.m. and 3:45 p.m., attempted to contact R10's nurse practitioner responsible for her pressure ulcer care, however, did not get a return phone call. R4 R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated 12/23/25, identified R4 was cognitively intact, had no behaviors,	F0686		

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F0686 SS = G	Continued from page 8 no rejection of care, no range of motion limitations on upper or lower extremities, need substantial/maximum assistance for rolling side to side, was dependent for sit to stand, dependent for chair to bed, at risk for pressure ulcers, no unhealed pressure ulcers, had MASD, treatments of pressure reducing device in chair and bed, application of nonsurgical dressings and ointments. R4's ADL focus care plan revised on 12/27/25, identified R4 had a self-care deficit related to weakness, history of stroke, cancer of the pancreas and liver, and diabetes with neuropathy (a type of nerve damage that happens with diabetes). Goal to improve current function in ADLs. Interventions as follows: -Bed mobility extensive assistance of two staff to turn and reposition in bed. -Partial assistance of two staff with a sit to stand mechanical lift for transfers. R4's skin integrity focus care plan revised on 1/7/26, identified R4 had a potential/actual impairment to skin integrity with old scarring from previous pressure injuries on bilateral buttocks related to incontinence of urine and stool. Goal to free from skin related infection. Interventions as follows: Wound/Skin treatment as ordered (date 12/18/25). -Use a draw sheet of lifting device to move resident (date 12/18/25). -lotion dry skin areas as necessary (date 12/18/25). -Skin barrier cream/ointment to protect skin as needed (date 12/18/25). -Pressure relieving/reducing pad while in chair (date 12/18/25). -Pressure reducing mattress on bed (date 12/27/25). -Assist with offload every two hours in bed and chair (date 12/27/25). R4's nursing home visit nurse practitioner note dated 12/22/25, identified R4 had been admitted with a wound to left buttocks (the note did not identify type of wound nor wound characteristics including measurements). The note included orders to cleanse wound with wound cleanser, pat dry, apply small amount of Iodosorb (antimicrobial gel directly to open wound area, cover with dry gauze and secure with foam dressing. R4's progress note dated 1/19/26, identified a situation, background, assessment, response (SBAR) was sent to physician that wound to buttocks in now open and bleeding. Buttocks has keloid skin to the right and skin tags that had an open area and the left had an open area as well. Asked for new treatment for the wound. The note did not include any further description of the wound. R4's physician orders dated 1/20/26, identified order to buttocks wounds as follows: -Wash per facility protocol and pat dry. Cover with silicone bordered foam dressing and change every 3rd day and as needed for rolling or getting soiled. (Start date 1/20/26 through 2/9/26). -Buttocks wounds peel dressing back to assess wound once daily. Start date 1/20/26 through	F0686		

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F0686 SS = G	Continued from page 9 2/9/26) R4's Skin Assessment dated 2/3/26, identified R4 had non-blanchable redness to the right buttocks near the gluteal cleft and bilateral buttocks had red/purple discoloration that was blanchable. Left buttocks had 1.2 cm x 1.2 cm open area. Corresponding progress note dated 2/3/26 included R4's bottom was starting to look macerated with non-blanchable redness noted to the right buttocks near the intragluteal cleft. R4's nursing home nurse practitioner note dated 2/6/26, identified a stage 2 pressure injury to the left medial buttocks and incontinence associated dermatitis. Pressure ulcer had three small open wounds on the left buttocks close together measuring 1.0 cm x 1.0 cm x 0.1 cm. More proximal (center of the body) on the left buttocks measures 1.5 cm x 1.0 cm x 0.1 cm. Edges attached and open. Wound bed denuded (loss of top layer of skin), fragile, and non-blanchable erythema. Minimal bloody drainage and tender with no odor. Periwound fragile and pink. Ulceration had gotten larger. Treatment orders as follows: -Wash buttocks wound per facility protocol, pat dry, cover with silicone bordered foam dressing, peel back daily to assess daily and change every 3rd day and as needed rolling/soiling. R4's Skin Assessment dated 2/6/26, identified R4 had thick scar tissue with 1.2 cm x 1.2 cm open wound to the left buttocks, with red/purple discoloration that is blanchable. Treatment orders in place. The assessment did not include further description of the wound nor address the second wound as identified by the NP. R4's Skin Assessment dated 2/13/26, identified R4's left buttocks had thick scar tissue with 1.2 cm x 1.2 cm open wound to left buttocks. Bilateral buttocks had red/purple discoloration that was blanchable. Identified as healing. No further description was included. Review of R4's record from 2/14/26 through 2/25/26 did not include a comprehensive wound assessment had been completed of R4's buttock wounds. During an observation and interview on 2/25/26 at 10:10 a.m., R4 was lying in a bed on top of a deflated air mattress that had been unplugged. There was no other barrier between the metal bedframe and the plastic material of the mattress. NA-C and NA-D entered R4's room, NA-D stated R4's air mattress was totally "deflated and must have been unplugged by accident." NA-D was unsure how long R4's mattress had been unplugged or when the last time R4 had been turned and repositioned in bed. NA-D then plugged R4's air mattress back in the outlet. R4 was assisted by NAs to stand up using a sit-to-stand lift exposing the back of R4's incontinent brief which had a silicone foam dressing stuck on the right side. NA-D stated, "How did that get there?, it is	F0686		

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F0686 SS = G	Continued from page 10 supposed to be on his wound on his bottom." As NA-D removed R4's brief an open wound was observed on R4's right buttock that was approximately 2.0 cm x 1.0 cm in size. The wound had uneven edges and was macerated (white, soft, wrinkled skin due to excessive moisture). Base of the wound was pink and R4 denied pain in the area. R4's bilateral buttocks had thick skin that was light brown (hyperpigmentation) in color with no redness or purple noted. NA-D stated R4 was going to get a shower, then the nurse would check his skin and apply a new dressing. During an interview on 2/25/26 at 10:45a.m., RN-B stated she had been told earlier that R4 had a new open area on his right buttocks and needed to put a dressing on it. RN-B explained that by R4's air mattress being deflated for an unknown time this could cause injury to R4's bottom. RN-B indicated she was not responsible for completing the comprehensive wound assessments, the nurse managers completed them. R4's Skin Assessment dated 2/26/26, identified R4 had moisture associated skin damage (MASD) to left buttocks measuring 2.5 cm x 1.0 cm; stage 2 pressure injury to right buttocks measuring 2.5 cm x 1 cm; and bilateral deep tissue injury measuring 9.0 cm x 8.0 cm. Wound identified as worsening. Assessment did not identify any further details of the pressure injury. R9 R9's face sheet dated 3/1/26, identified diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's significant Change MDS dated 1/26/26, identified R9 had intact cognition, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was dependent for chair/bed to chair transfers, was at risk for developing pressure ulcers, had one stage 2 pressure ulcer, R9's Braden Scale for Predicting Pressure Sore Risk dated 1/26/26, identified R9 was moderate risk for developing pressure ulcers due to being slightly limited in sensory perception, being occasionally moist, chairfast, completely immobile, problem with friction/shear. R9's ADL focus care plan revised on 5/21/25, identified R9 had a self-care deficit related to weakness, respiratory failure, and kidney failure. Goal to maintain current level of function. Interventions as follows: -Transfers: dependent with assist of two staff using a full body mechanical lift. -Bed mobility: dependent with one to two staff for repositioning and turning in bed. R9's pressure ulcer focus care plan dated 5/21/25, identified R9 had potential for pressure ulcer development related to history of ulcers and immobility. Goal to have intact skin. Interventions as follows: -Assist of two staff to turn and reposition	F0686		

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F0686 SS = G	Continued from page 11 every 2 hours in bed and chair, more often as needed or requested. Pressure relieving mattress on bed (dated 2/16/19). -Pressure reducing device on wheelchair (dated 12/16/19). -Lay resident down between meals and prop to either side using pillows to fully offload buttocks. If refused report to the nurse (dated 1/28/26). -May leave lift sling under due to discomfort with removing and replacing. Skin checks increased to twice per week (dated 1/28/26). R9's Skin Assessment dated 1/13/26, identified left buttocks wound with an open area that measured 0.5 cm x 0.5 cm, no drainage, center is red in color. Mepilex dressing applied. The assessment did not include any other characteristics. R9 nurse practitioner nursing home visit note dated 1/13/26, identified R9 had been having severe pain in buttocks for past 3 weeks with pain relieved by lying flat in bed. Stage 2 pressure ulcer on left buttocks identified. Treatment orders to wash per facility protocol, pat dry, cover with silicone bordered foam dressing, change every 3rd day and as needed and frequent repositioning and offloading pressure. In review of R9's record despite the order for frequent repositioning/offloading there was no indication of a comprehensive assessment to determine the frequency of repositioning nor evident the care plan was revised with a change from every two hour positioning which was identified as an intervention on 2/16/19. Review of R9's Skin Assessments dated 2/3/26 through 2/21/26 indicated the measurements of the left buttock wound remained the same. The assessments each identified a wound with an open area that measured "approximately" 1.3 cm x 0.75 cm. Area cleansed and patted dry, skin prep and bordered foam dressing applied on each assessment. The assessments did not include any other wound description or characteristics. R9's Skin Assessment dated 2/24/26, indicated the wound to the left buttock had deteriorated. The assessment included the wound had an open area, wound bed appears superficial, pink/red in color, no drainage, measures 2.5 cm x 3.0 cm. New bordered foam dressing applied. The assessment did not include any other wound description or characteristics. R9's Weekly Wound/Complex Wound Observation Tool dated 2/27/26, identified R9 had a stage 2 pressure ulcer on left buttocks that measured 0.8 cm x 1.6 cm with no depth. Wound was acquired while in the facility. - During an interview on 3/2/26 at 12:40 p.m., LPN-C stated R9 was turned and repositioned every 2 hours while in bed and the chair, which he allows. R9's wound on his left buttock has been improving with turning and repositioning and treatments. LPN-C further explained that the skin assessments that were done on bath	F0686		

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F0686 SS = G	Continued from page 12 days were not comprehensive assessments because many of them were completed by LPN's and not an RN. LPN-C was unsure which registered nurses was responsible for the assessments and staging of a wound. During an interview on 2/26/26 at 2:06 p.m., Minimum Date Set Coordinator Registered Nurse (MDS-RN) stated she had noticed "a while ago" that residents with pressure ulcers had not had a weekly comprehensive wound assessment of their wounds completed and had informed her concern to upper management, but continued to notice that the comprehensive assessment have not been completed. During an interview on 3/2/26 at 3:07p.m., RN-NM stated she had not been performing any comprehensive assessments of residents with pressure ulcers and was not aware that a registered nurse needed to complete the comprehensive assessment each week. RN-NM explained she had not been given directions to be responsible for completing the wound assessment for the residents with pressure ulcers; the only direction she received to ensure the weekly bath skin assessments by the floor nurses. RN-NM further explained she had not received any wound assessment education and without having this education she would not "feel comfortable" performing the assessments also RN-NM believed that any staff could assess the wounds and was not aware a registered nurse would need to complete the assessment to ensure it was correct and appropriate treatments and pressure reducing measures were in place. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated registered nurse manger (RN-NM) had been assigned the responsibility of ensuring the weekly pressure ulcer assessments were being completed. DON explained when she started reviewing wound documentation she realized the weekly skin bath audits were completed however, not the comprehensive wound assessments. Any resident with pressure ulcers should have had a weekly comprehensive registered nurse (RN) assessment of the wounds to ensure the appropriate treatment and pressure prevention measures were in place. The comprehensive assessment should have included: type of wound, location, date acquired, staging, length, width, depth, description of wound base, edges, and drainage. DON reviewed R10, R4, R9's record and identified no RN weekly comprehensive wound assessments had been completed since identification of the pressure ulcers and they "should have been completed." DON explained the purpose of the comprehensive assessment being done by an RN would be to ensure the pressure ulcers are assessed for healing and/or deterioration and to ensure proper pressure relieving measures/treatments are in place. Review of the facility's Prevention and Treatment of Skin Breakdown Policy undated, identified it was the	F0686		

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F0686 SS = G	Continued from page 13 policy of the facility to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Procedure as follows: Skin Ulcer Data Collection & Assessment sheets are used for pressure, stasis, arterial and neuropathic ulcers. Data is provided by the floor nurse or nurse manager on resident's bath day. RN assesses the information and writes a progress note detailing the wound appearance, treatment, and healing progress. Treatment orders to be followed as MD prescribes, measurements of wounds only need to be documented weekly. If wound worsens consecutively for 2-3 weeks a note to the MD is sent with request for new orders. Prevention of Pressure Ulcers A. Braden Scale* and Comprehensive Risk Data Collection form (which includes a skin audit) will be done: • Upon admission • Weekly for the first 4 weeks post admission, • Quarterly, and • With a change in status (i.e., pressure ulcer development, change in mobility, continence status, Change in cognition, nutrition, etc.). Please see Policy and Procedure for Braden Scale & Comprehensive Risk Data Collection in the Forms and Care Plans section for instructions. A. Turning and Repositioning Observation (capturing turning & repositioning). Pressure is the primary cause of pressure ulcers. An effective turning and repositioning schedule can help reduce the risk of developing a pressure ulcer. Everyone's tissue tolerance (the ability of the skin and its supporting structures to endure the effects of pressure without breakdown), is different. Therefore, it is important to individualize each resident's turning and repositioning schedule. For those residents that are immobile, or need assistance with mobility, complete a Turning and Repositioning (Tissue Tolerance) Observation form: • Upon admission, • Re-admission, • With a change of condition (including the development of a pressure ulcer or change in mobility status), • Annually and, • In both the lying and sitting position. B. Monitoring of Skin Integrity • Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. • Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse	F0686		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	F 689 Affected residents	04/02/2026

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F0689 SS = SQC-J	Continued from page 14 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility /failed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4 and R9) reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed to /comprehensively investigate/analyze falls for root cause, implement /appropriate interventions /to prevent and/or reduce the risk for future falls /for 1 of 3 residents (R3) reviewed for falls/safety. The IJ began on /2/25/26, /when nursing assistant (NA)-C and NA-D had to be stopped from using the wrong harness size according to R4's care plan and the failed to follow manufacturer's instructions to tighten the harness torso strap to ensure safety putting R4 at likelihood for serious harm/injury or death. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 2/26/26 at 6:08 p.m. The immediate jeopardy was removed on /3/2/26 at 2:30 p.m., /but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated 12/23/25, indicated R4 did not have cogntive impairment, had no behaviors, no rejection of care, no range of motion limitations on upper or lower extremities, was dependent for sit to stand, and was dependent on staff for chair to bed transfer. Additionally, R4 had a fall in the last month prior to facility admission, had a fall within the last 2-6 months since admission with no injury, and had one fall since admission with injury. R4's Morse	F0689	Continued from page 14 Resident R 4 was reassessed for harness size on 2/27/2026 Therapy reassessed transfer status of R4 on 2/27/2026 Care plan/Kardex was updated to reflect any changes Resident R 9 was reassessed for sling size on 2/27/2026 Therapy reassessed transfer status of R 9 2/27/2026 Care plan/Kardex was updated to reflect any changes Identification of others All residents using the mechanical lifts or have the potential to use a lift were assessed for: Correct sling/harness size by the Director of Nursing on 2/27/2026 Proper transfer method by therapy on 2/272026 Care plan/Kardex accuracy on 2/27/2026 Systemic Corrections Mechanical lift transfer policy reviewed and updated to Require sling/harness size documented in the care plan/Kardex Require 2-assist transfers when indicated Require staff verification of sling size prior to transfer Determination of sling/size will be done a licensed nursing or therapy department Determination of lift type may be done by a licensed nurse or therapist upon admission or identified changes in transfer status	

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F0689 SS = SQC-J	Continued from page 15 Fall Scale (a tool used to determine risk of falling) dated 12/18/25, identified R4 as a high-risk for falling due to weakness and history of falling. R4's Therapy Recommendation form dated 12/18/25, identified R4 needed assistance of two staff with the sit-to-stand mechanical lift for all transfers with large harness due to needing cues for hand placement. R4's fall focus care plan dated 12/27/25, identified R4 was at risk for falls related to history of falls before and after admission. Goal to be free from falls. Interventions dated 12/18/25 as follows: -Call light within reach. Encourage use of call light for assistance as needed. -Ensure resident is wearing appropriate footwear (non-skid socks or rubber soled shoes) during transfer, ambulation and/or mobilizing in wheelchair. -In the event of fall, resident will need assistance of two staff with a total mechanical lift and a large sling. -Routine safety checks. -Follow facility fall protocol. R4's Activity of Daily Living (ADL) focus care plan initiated on 12/18/25, identified R4 had an ADL self-care performance deficit related to weakness, history of stroke, cancer of the pancreas, and diabetic with neuropathy (damage to the nerves resulting in pain, numbness, tingling, or weakness especially in the hands and feet). Goal to improve current level of function in ADLs. Interventions dated 12/19/25 directed staff for toilet use: R4 required assistance from two staff for all transfers with a sit to stand mechanical lift and for transfers R4 required assistance from two staff members for "all transfers." R4's nurse aide resident care sheet dated 12/21/26, identified R4 needed assist of two staff with the sit-to-stand mechanical lift with a large harness. During an interview on 2/25/26 at 7:45 a.m., trained medication aide (TMA)-B explained staff would use the therapy recommendation or the paper care sheet (not the care plan or kardex (abbreviated care plan)) to determine what size harness a resident required when using the sit-to-stand lift. R4's progress note dated 12/21/25 at 1:56 p.m., identified the nurse was called to R4's room and found that R4 had fallen from the sit-to-stand mechanical lift. R4 was lying on the floor with his feet still on the sit-to-stand with the leg strap still buckled and his head resting on the recliner. "Isolated incident care plan was not followed by nursing assistant and was transferred by one person using the sit-to-stand mechanical lift." Noted a friction bruise that was reddish in color under left armpit from the sling. R4 was changed to a total mechanical lift until therapy can re-assess. Educated staff on importance of following care plan and two staff for cares and transfers. R4's record did not identify the size of sling used and not evident a	F0689	Continued from page 15 Care plans updated to specifically identify: Type of lift Assist level Sling/harness size Care sheet eliminated on 3/2/2026 Education Some nursing staff that use or the potential to use a mechanical lift were re-educated on 2/27/2026 by the director of Nursing Manufacturers recommendations Proper harness/sling use When sit-to-stand lift is contraindicated Care plan/Kardex to follow Staff not in attendance are required to be competency tested to use a mechanical lift and Kardex by a Registered nurse prior to working. All newly hired nursing staff and contract staff will have competency training by a Registered Nurse Representative from Ez Way gave education to nursing staff on 3/18/2026 Monitoring/Oversight The Director of Nursing Designee will conduct audits to ensure that staff are following the protocol for proper lift use Audits conducted 2 x per week for 4 weeks 1 x per month for 3 months	

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F0689 SS = SQC-J	Continued from page 16 comprehensive assessment was completed to determine sling size for the full body mechanical. Additionally, the care plan was not revised to include intervention(s) for R4 falling asleep in the lift. R4's fall incident report dated 12/21/25 at 12:23 p.m., identified R4 had a witnessed fall from the sit-to-stand mechanical lift. /Writer witnessed the patient lying on the floor with his feet still in the /sit-to-stand mechanical lift /with leg strap still buckled, head propped up on the footrest of the recliner, which was down at the time. /Resident description was that R4 felt weak and let go of the /sit-to-stand mechanical lift /and his arms went up and he fell. R4's Fall Root Cause Analysis and Witness Statement form dated 12/21/25, identified R4 was supposed to have two staff members for all transfers with the sit-to-stand however, according to witness statement the nursing assistant attempted transfer by herself from wheelchair to the recliner while R4 fell asleep during transfer and fell. R4 felt weak and arms went up when he let go of the sit to stand mechanical lift and fell. During an interview on 2/26/26 at 11:06 a.m., nursing assistant (NA)-E stated on 12/21/26, R4 had asked for a brief change and wanted to be transferred from his wheelchair to his recliner. NA-E stated she was aware R4 needed two staff to transfer using the sit-to-stand mechanical lift, so she had requested assistance over the walkie talkie but did not get a response. NA-E stated she had not verified R4's care plan/care sheet and/or therapy sheet to see what size sit-to-stand harness R4 was supposed to use. NA-E stated with conviction she was "100% positive she used an extra-large [XL] harness to transfer R4, because R4 was the only resident using the sit to stand lift in that unit and staff kept the sling at all times on the lift." NA-E then proceeded to transfer R4 by herself. NA-E stood R4 in the sit-to-stand mechanical lift, performed pericare as R4 stood up, pulled R4's pants back up, and then turned and then pushed the lift towards the recliner. Once in front of the recliner R4 began to fall asleep, he let go causing him to slip completely out of the lift harness onto the ground. Review of the facility investigation notes identified NA-E was not contacted until 12/22/25 by an unknown staff member. On 12/22/25 NA-E stated she was aware R4 needed assist of two staff with the sit to stand lift, but other staff were busy, so she needed to get R4 cleaned up and moved. NA-E informed DON she had checked R4's care plan and verified harness size (notes did not identify what size harness NA-E used at the time of the transfer), attached the harness and buckled R4's feet and decided to then lift R4 up in the lift. NA-E cleaned and changed R4's pad and then was going to transfer R4 to the recliner but when NA-E	F0689	Continued from page 16 Results to be reported the QAPI for review and any further recommendations Compliance 4/2/2026	

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F0689 SS = SQC-J	Continued from page 17 was positioning R4 near the recliner, R4 slipped out, fell to the ground. R4 told NA-E he had fallen asleep and she then called the nurse. During an interview on 2/26/26 at 12:02 p.m., licensed practical nurse (LPN)-C stated on 12/21/25 at around 12:30 p.m. she had been called to R4's room by NA-E over the walkie talkie to report R4 had fallen from the lift. Upon entering R4's room she found R4 sitting on the floor in front of his recliner with both of his legs still resting on the lifts' foot plate with the calf strap still buckled. The harness was still connected to the lift with the torso strap still buckled; the harness was connected to the lift appropriately. LPN-C had not verified that R4's harness was the correct size after the fall, "I did not even think to check." LPN-C explained she thought R4 fell out of the lift because NA-E had not cinched the torso strap tight so when R4 let go he slipped completely out of the harness. LPN-C further stated R4 had pain in his left shoulder for some time after the fall which was treated with pain cream. During an interview on 2/26/26 at 12:44 p.m., the Director of Nursing (DON) stated she was notified on 12/21/25 that R4 had fallen from the sit to stand lift. Following the notification, the DON immediately removed NA E from the work schedule. She reported attempting to interview NA E shortly after the incident but was unable to reach her at that time. DON returned to the facility later that afternoon, inspected the lift and harness, and noted no apparent defects. She reported she was not aware that an XL harness had been used during the transfer; she believed a large sling had been used but had no documentation verifying the harness size at the time of the fall. DON interviewed NA E on 12/22/25. During that interview, NA E reported she had transferred R4 alone and did not utilize a second staff member as required by policy and the resident's care plan. NA E had stated that R4 fell asleep during the transfer, released her hold on the equipment, and subsequently slipped out of the sling. DON reported she did not recreate the incident with NA E to determine the cause of the fall and did not have documentation of any post incident inspection of the lift or harness. DON kept NA E off the schedule until NA E completed a repeat competency test on the safe use of mechanical lifts. DON reported conducting multiple competencies and audits on NA E only and acknowledged she did not perform audits or provide additional staff education regarding adherence to care plans for any other staff members. DON stated she did not believe improper lift use was a systemic issue and therefore limited education and competency review to NA E. R4's progress note dated 12/22/25, identified R4 was complaining left shoulder was sore. R4 pointed to left	F0689		

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F0689 SS = SQC-J	Continued from page 18 shoulder and had an “ache” and with range of motion (ROM) had pain. R4 was seen by nurse practitioner virtually and no x-ray ordered. R4’s nurse practitioner note dated 12/22/25, identified R4 was seen due to pain in left shoulder following a fall from the sit-to-stand mechanical lift on 12/21/25. Physician order for /Voltaren (pain cream)1% gel; Apply 2 g topically 4 (four) times a day. May also apply 2 grams four times a day as needed (shoulder pain). R4’s Medication Administration Record (MAR) reviewed 12/23/25 through 1/5/26 identified Voltaren cream had been applied to R4’s left shoulder 14 times. R4’s care plan revised on 2/24/26, identified R4 required assistance from two staff using sit-to-stand mechanical lift. R4’s resident care guide reviewed on 2/25/26, identified R4 needed assist of two staff with sit-to-stand mechanical lift with a large harness. During an observation and interview on 2/25/26 at 9:31 a.m., NA-C and NA-D entered R4’s room to assist R4 with transfer from bed to shower chair. NA-D brought in a sit-to-stand mechanical lift with a harness draped over the top of the lift. NA-D stated R4 was the only resident on the wing that used the sit-to-stand lift and that his (XL) harness was draped over the lift. NA-D stated twice the XL was the correct size for R4. NA-C and NA-D then sat R4 at the edge of the bed and placed the XL harness behind R4’s back. Surveyor intervened and asked NA-C and NA-D to verify that the XL harness size was the correct size to use with R4. Neither NA-C nor NA-D had a resident care guide that identified R4's correct harness size. NA-D left the room to find out the correct harness size R4 was supposed to use and returned to R4’s room with a large harness. NA-D stated she verified R4’s resident care guide and it identified R4 was to use a large harness not an XL. NA-D stated she had to go to another wing in the building to find the correct harness size for R4, because the size was not in R4’s unit. Registered nurse (RN)-A then entered R4’s room and stated R4 had been assessed by therapy and was suppose to be using a large harness, RN-A stated R4’s care plan/kardex did not identify harness size , but the resident care guide did specify the correct size and staff should be checking in all places to verify they are using the correct harness. NA-C and NA-D then placed the large harness behind R4’s back, applied the loops, provided cues to have proper hand placement to R4, attached the leg and torso strap, had R4 stand. As R4 stood, NA-C nor NA-D cinched the torso strap. Surveyor intervened to instruct NA-C and NA-D to cinch the torso strap as R4 stood. NA-C stated she was aware the torso strap needed to be cinched as a resident stands up, but must have just overlooked doing it. NA-C stated a resident could fall	F0689		

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F0689 SS = SQC-J	Continued from page 19 out of the lift if this is not done each time they stand up and she should have made sure this was done. NA-C and NA-D stated they had not received any re-education on the proper use of mechanical lifts nor following care plan since their initial orientation. During an interview on 2/25/26 at 10:30 am., director of nursing (DON) verified R4's care plan/Kardex did not identify R4's harness size staff are supposed to use during a transfer with a sit to stand lift. DON stated R4 was supposed to be using a large harness and it had been identified on the resident care sheet, but should have been added to the care plan/Kardex. DON stated staff were supposed to use the Kardex and/or resident care guides to verify correct harness size prior initiating a transfer with the lifts. During an interview on 2/26/26 at 4:26 p.m., medical director (MD) stated any resident being transferred using a mechanical lift without a care plan and/or policy followed for use of the mechanical lift had the likelihood to cause serious harm, serious injury, or even death in the event the resident falls from the mechanical lift. R9 R9's face sheet dated 3/1/26, identified R9 had diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's Significant Change MDS dated 1/26/26, identified R4 was cognitively intact, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was dependent for chair/bed to chair transfers. R9's Mechanical Lift Sling/Harness Sizing Assessment dated 2/27/26, identified R9 needed a large sling for the total mechanical lift. R9's ADL focus care plan dated 5/21/25, identified R9 had a self-performance deficit related to weakness, chronic respiratory failure, and schizophrenia. Goal to maintain current level of functioning. Interventions as follows for transfers: -EZ stand harness size large (R9 did not use an EZ stand lift); Total mechanical lift sling: (was left blank). Dated 2/27/26. -Transfer: The resident requires total dependence on two staff for transferring via total mechanical lift with an XL sling. Dated 1/8/26. R9's Kardex reviewed on 3/2/26 at 10:00 a.m., identified R9 needed a XL sling for with the total mechanical lift, however, this conflicted with the assessment dated 2/27/26 that identified R9 required a large sling. During an interview on 3/2/26 at 10:14 a.m., DON reviewed and verified R9's care plan/Kardex conflicted with the assessment dated 2/27/26. DON confirmed R9 had been measured and assessed for proper sling size on 2/27/26, determined he needed a large sling verses an XL sling. DON was not aware R9's care plan/Kardex had not been updated to reflect the correct sling size of a large sling. During	F0689		

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F0689 SS = SQC-J	Continued from page 20 an observation and interview on 3/2/26 at 10:39 a.m., R9 was seated in wheelchair on top of mechanical lift sling that was in color with green trim. Trained medication aide (TMA)-C entered R9's room and stated that she was unable to verify what size R9's sling by the tag, due to the sizing being washed off. TMA-C stated a tan sling with green trim would be an /XL /sling. TMA-C then walked to a mechanical lift, identified the sling color with the coding sizing chart on the front of the lift that indicated a green trim sling was indeed an /XL /sling. TMA-C then verified on R9's Kardex that R9 was supposed to be in a large sling and not an XL sling during transfers using the total mechanical lift. TMA-C stated, "R9 could have fallen out of that sling, and we are lucky he did not." During an interview on 3/2/26 at 11:03 a.m., DON stated NA-D informed her that she had not transferred R9 using the correct sling size, NA-D had only verified the sling size by using the paper nurse aide care guide. DON explained using the sling that was too large could have caused R9 to fall out of the sling during a transfer. DON and TMA-C then removed the incorrect sling out from under R9 and placed the correct size sling in R9's room to be used for the next transfer. DON stated R9's care plan had been amended to remove any XL sling off his care plan and the paper care sheets removed off the floor to ensure staff were checking the same place to verify correct sling sizes for any residents that need to transferred using any mechanical lift. The immediate jeopardy that began /on 2/25/25 was removed on 3/2/26 at 2:30 p.m., when it was verified, the facility implemented the following: - The facility has identified all those that use a sit to stand. The facility has assessed each resident and the size of harness needed. The facility educated each member of the nursing staff that will or had potential to use the sit to stand. - R4 and all residents using mechanical lifts were assessed for: Proper transfer method Correct sling/harness size Care plan accuracy. - Sling/harness size was verified for each resident through: Therapy documentation Direct measurement Manufacturer guidelines Care plan accuracy. -Systemic Corrections Policy Review Mechanical lift transfer policy reviewed and updated to: Require sling/harness size documented in care plan and Kardex. Require 2-assist transfers when indicated. Require staff verification of sling size prior to transfer. Require cinching of waist/middle straps before elevation. Documentation Care plans updated to specifically identify: Type of lift Assist level. Sling/harness size. Kardex updated to match care plan. Care sheets updated to match the care plan -Education All licensed nurses and other	F0689		

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F0689 SS = SQC-J	Continued from page 21 certified individuals: Manufacturer recommendations Proper sling application Proper strap placement and cinching When sit-to-stand lifts are contraindicated. Always following care plan Education included: In-service training Hands-on demonstration Return competency validation. Competency Quiz Review of the facility's Mechanical Lift Policy dated 12/25, identified it is the policy to lift and move a resident safely without causing serious injury to staff or residents. Procedure as follows: -All mechanical lifts require two staff for operation. -All staff will be trained on proper lift use prior to operating mechanical lifts. -Lifts will be inspected per manufacturer's recommendations. -Lift slings are inspected by nursing prior to use and by laundry when washed. -Inspections will be audited and reviewed and monthly safety meetings. R3 R3's face sheet dated 2/27/26, identified diagnoses of malignant neoplasm of the brain, heart failure, and osteoporosis. R3's significant change MDS dated 2/16/26, identified moderate cognitive impairment, no behaviors, no rejection of care, used a walker and wheelchair, needed partial/moderate assistance for transfers, had one fall with no injury and one fall with injury since admission. R3's fall focus care plan initiated on 1/9/26, identified R3 was at risk for falls related to limited mobility, communication issues, and weakness. Goal to be free from falls. Interventions as follow: -Follow facility fall protocol. -Routine safety checks. Start date 1/9/26. -Anticipate and meet the resident's needs. Start date 1/9/26. -PT evaluate and treat as ordered. Start date 1/9/26. -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes. Start date 1/9/26. -Be sure the residents' call light is within reach and encourage the residents to use it for assistance as needed. The resident need prompt response to all requests for assistance. R3's fall incident report dated 2/10/26 at 1:40 p.m., identified R3 had an unwitnessed fall in the bathroom after being assisted by a family member and being alone for a minute. R3 attempted self-transfer and fell on her buttocks. Family member assisted R3 off the floor and reported the fall to staff. R3's Incident Root Cause Analysis Worksheet dated 2/10/26, identified problem that R3 was left unattended while in the bathroom. Root cause of fall was left blank. /There was no /indication /of a comprehensive analysis to /identify /potential causal factors. R3's fall focus care plan was revised on 2/11/25 to encourage family members not to transfer	F0689		

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F0689 SS = SQC-J	Continued from page 22 resident and to ask for staff for assistance. R3's fall incident report dated 2/18/25 at 1:50 a.m., identified R3 was on the bathroom floor with her walker located outside of the bathroom door. Predisposing physiological factors of weakness, gait imbalance, drowsy. Predisposing situation factors of ambulating without assist devices. /R3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls. R3's Incident Root Cause Analysis Worksheet dated 2/18/26, identified a problem that R3 self-transfers at times without a walker. Root causes of fall identified as brain cancer, weakness, and self-transfers. Although the analysis idetentified potential causal factors, there was no indication of a comprehensive analysis that determined associated interventions that would decrease the risk or prevented falls based on the causal factors that were identified. R8's care plan revised on 2/19/26 directed staff to place dycem (anti-slip) mat placed in seat of wheelchair, /however, it could not be determined the rational for placement of the dycem based on the identified causal factors of the fall that were identified on the causal analysis worksheet. R3's fall incident report dated 2/20/26, identified R3 had an unwitnessed fall in her room at 8:05 a.m. R3 was found on the floor lying next to her bathroom. /R3 had independently walked to the bathroom by herself and lost her balance. /R3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls. R3's Incident Root Cause Analysis Worksheet dated 2/20/26, identified R3 was found outside of her bathroom on the floor, visual checks every 30 minutes cannot be done when nursing assistants in rooms providing care (R3's record did not identify 30-minute checks had ever been initiated). Had an inquiry about adding an ultra-low bed. /In review of R3's record although a potential cause was identified there was no indication 30-minute checks had ever been initiated. Additionally even though R3's care plan had been revised 2/25/26 (5 days after the fall) directed staff to check and change every two hours and offer bedpan if the R3 chose, there was no corresponding comprehensive assessment that identified how the frequency and type of toileting program was determined. During an interview on 2/27/26 at 1:16p.m., DON stated R3's falls had been discussed during the IDT daily meetings, however, had not had a comprehensive causal analysis done for each fall to ensure that person-centered interventions were put in place for each fall. DON indicated toileting was the root cause of her falls and should have been addressed before 2/25/26 Review of the facility's Falls-Clinical Protocol dated 2/26, identified the following: Cause	F0689		

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F0689 SS = SQC-J	Continued from page 23 Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify potential causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. 2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. /After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. /Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling. 3. The staff and physicians will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable.	F0689		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility /failed to /ensure that 1 of 1 resident (R1) was free of a significant medication error by not /observing /the rights of medication administration. This caused actual harm for R1 when she was administered another resident's /medications /became /unresponsive and /had to be hospitalized for hypotension and acute kidney injury. In addition, based on observation and interview the facility failed to ensure appropriate correction measures after R1's medication errors to decrease the risk or reduce the risk of significant medication errors and could have prevented or reduced the risk additional medication errors that were not significant for 2 of 2 residents (R12, R5) observed during medication pass. Findings include: R1's face sheet dated 2/27/26, /identified /diagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners). R1's admission Minimum Data Set (MDS) dated 2/13/26, /identified /R1 had	F0760	F 760 Immediate Action R1 was immediately assessed by the licensed nurse after R1 received the wrong medication. Vitals were taken by the licensed nurse Provider was notified on 2/13/2026 Orders were given to monitor the residents for any adverse reactions. Identification of other Residents All residents have potential to be affected by the medication error. The Medication Administration Record was audited for discrepancy by the Director of Nursing on 2/13/2026. No additional errors were found.	04/02/2026

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F0760 SS = G	Continued from page 24 moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant. R1's physician orders /identified /the following: -Midodrine (a drug used to treat orthostatic hypotension /and increase blood pressure) 5 mg three times per day related to orthostatic hypotension. Do not take if systolic blood pressure (top blood pressure) if greater than 150. -Vitamin D (supplement) tablet /50 /micrograms (mcg) one time per day. -Pantoprazole (drug to reduce stomach acid) /40 /milligram (mg) one time per day. -Apixaban (blood thinner) 5 mg by mouth one time per day. -Rosuvastatin (drug to treat high cholesterol) 20 mg one time per day. -Calcium carbonate (supplement) 1500 mg 2 tablets two times per day. R1's Medication Error incident report dated 2/13/26, /identified /R1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for evaluation. /The investigation notes identified the medications that R1 received included: Atorvastatin 40 mg (milligrams-lipid/cholesterol management), Clopidogrel 75 mg, (antiplatelet-increases risk for bleeding) Duloxetine 30mg, (antidepressant) Empagliflozin 10 mg (diabetic management), Famotidine, (reduces stomach acid) Lamotrigine 100mg (anticonvulsant/mood stabilizer), Losartan 25 mg (treats hypertension) Metoprolol 25 mg (treats hypertension/heart rate control) Potassium 20 mEq,(treats low potassium) and Torsemide 20 mg /(diuretic and hypertension) R1's progress note dated 2/13/26 at /7:35 a.m., /identified /nurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident's /medication /by mistake. Nurse called the on-call physician and informed the medications /R1 received and was instructed to /monitor /resident for any adverse reactions to any of the medications. R1's progress note dated 2/13/26 at 9:20 a.m., /identified /nurse was called into R1's room by nursing assistant because R1 became unresponsive. R1 was lying with eyes closed, did not respond to verbal commands. "Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace." Blood pressure 137/82 (normal blood pressure is under 120/80) and heart rate 92 (normal heart rate is 60-100), respirations 18 (normal respirations 12-18), oxygen saturations 97% (normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED). R1's emergency department (ED) note dated 2/13/26, /identified /R1 was seen in the ED after becoming unresponsive after	F0760	Continued from page 24 Systemic changes All Trained Medication aids were competency checked by the DON/RN designee to include the Rights of Medication on 2/13/2026 – 2/15/2026. All licensed nurses were competency checked by the DON/RN designee to include the Rights of Medication on 2/13/2026 – 2/15/2026. Any staff that had not worked or new hires will be competency checked by a registered nurse prior to working and independently administering medication. Monitoring The DON/designee will conduct random medication pass audits 3 x per week for 4 weeks and then a random medication pass audit 1 x per week x 3 weeks. The DON/designee will conduct monthly medication pass audits x 3 months. Results of the audits to be reported to QAPI for review and any further recommendations Completion 3/27/2026	

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F0760 SS = G	Continued from page 25 receiving another resident's medications at 7:35 a.m. A list of medications that was administered was as follows: Atorvastatin 40 mg, Clopidogrel, 75 mg, Duloxetine 30mg, Empagliflozin 10 mg, Famotidine, Lamotrigine 100mg, Losartan 25 mg, Metoprolol 25 mg, Potassium 20 milliequivalent (mEq), and Torsemide 20 mg. R1 had become somnolent (sleepy) and not acting herself at the nursing home so was sent to ED for evaluation. /Blood pressure on admission to the ED was 133/59. Blood urea nitrogen (lab value to evaluate kidney function) "slightly up trending." /R1's blood pressure at 10:58 a.m., decreased to 97/48 millimeters of mercury (mm/Hg) and one liter of fluid bolus /initiated. R1 was admitted /for /monitoring /for hypotension and resolution of a mild acute kidney injury. R1's hospital progress note dated 2/14/26, /identified /diagnoses of accidental drug ingestion, hypotension secondary to accidental drug ingestion, blurry vision secondary to accidental drug ingestion, and orthostatic hypotension. On 2/14/26 /she endorsed blurry vision which the note /identified /this could be a side effect of the medication of the low blood pressures. R1's hospital discharge summary dated 2/17/26, identified R1 had been hospitalized 2/13/26 through 2/17/26 after being inadvertently administered another patient's medications at a skilled nursing facility. On presentation R1 was somnolent (sleepy and or drowsy) and did not follow commands, had a single episode of hypotension that responded to intravenous (IV) fluids. Laboratory evaluation revealed an acute kidney injury with a creatinine elevated to 1.36 milligram/deciliter (mg/dl). The medication error of receiving medications not prescribed to R1 and was admitted for close monitoring of hemodynamics and renal (kidney) function. R1 experienced symptomatic orthostatic hypotension with dizziness and blurry vision on standing, /required /ongoing conservative management including compression wraps, abdominal binder, hydration, and gradual titration of midodrine to 10 mg three times per day. R1's acute kidney injury resolved with IV fluids and avoidance of nephrotoxic agents (medication that cause kidney damage). R1 was discharged on 2/17/26 to another skilled nursing facility. During an interview on 2/24/26 at 4:06 p.m., trained medication aide (TMA)-A /stated /she was agency staff and had worked a handful of times at the facility. She had not worked with R1 before and had not seen R1 before. During the day shift on 2/13/26, TMA-A prepared R2's medications, verified R2's picture in the electronic health record (EHR), /identified /R2's room number, however, TMA-A entered R1's room instead. TMA-A did not verify the room number prior to entering R1's and /then entered R1's room to administer the	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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F0760 SS = G	Continued from page 26 medications. TMA-A then /proceeded /to administer R2's medications to R1. /When TMA-A /attempted /to give R1 an inhaler R1 stated, "I don't take an inhaler.", TMA-A realized her error. /TMA-A left R1's room and /verified on the EHR that she had mistakenly given R2's medications /to R1. TMA-A immediately /called the nurse to inform them of error and took R1's vital signs. TMA-A /stated /she did not follow the rights of medication administration to ensure the correct resident received the correct /medications. TMA-A further /stated /she had not had /orientation /on medication pass or any /previous /education on rights of medication administration /at this facility. During an interview on 2/24/26 at 1:44 p.m., licensed /practical nurse (LPN)-B /stated /she had been notified by TMA-A on 2/13/26 around 7:30 a.m., that R1 received R2's medications. LPN-B /stated /she /immediately /came to the unit to check on R1. R1's vitals were /stable; however, she was concerned about getting the wrong /medications. LPN-B /stated, "I don't even know how TMA-A made that kind of error and told her she should have verified she was giving the medications to the right resident." LPN-B further /stated /if TMA-A had performed her rights of medication administration she would have not made the mistake. During an interview on 2/25/26 at 1:04 p.m., medical director (MD) /stated /she considered R1's medication error that occurred on 2/13/26 to be considered a significant error. MD further stated R1 becoming hypotensive and developing an acute kidney injury was /likely caused /by getting medication that were not prescribed to her. Staff should have followed the rights of medication administration /for all residents /to /ensure safe medication administration /utilized. During an interview on 2/20/26 at 4:04 p.m., director of nursing (DON) /stated /she had been informed 2/13/26 at 8:00 a.m., that R1had inadvertently received R2's medications at 7:30 /a.m. DON /stated /she instructed the nurse to /monitor /and ensure the physician had been informed of R1's medication error. The nurse had informed DON that R1 was doing "fine" and she was being /monitored. DON then /arrived /at the facility around 8:45 a.m. /to /9:00 a.m. Shortly after the DON arrival she /was /notified /that R1 had become unresponsive. DON then /immediately /went to R1's room where R1 was found lying in bed and not responding /to verbal commands. R1's vitals /had been /taken and were stable, but continued to not respond, so /DON /sent /R1 to the ED for evaluation. DON stated R1's medication error occurred because the rights of medication administration had not been followed /by TMA-A and the wrong medication was given to the wrong resident. R1 was admitted /for observation, but did not return to the facility, so she did not know the outcome. /TMA-A had told DON that	F0760		

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F0760 SS = G	Continued from page 27 as /she prepared R2's medications, believed she had /entered R2's room, however after administering R1 all of R2's pills, she had tried to /offer R1 an /inhaler, /when R1 stated /that /was not her medication. TMA-A /then /told her she realized she had given medications /to the incorrect resident and notified the nurse immediately. DON then sent TMA-A home and /stated /she had provided /verbal education to the staff that was /working on /the rights of medication administration, however, did not have any documentation of her education provided. DON /stated /the facility then began competency testing of the staff that administered medication to ensure that the rights of medication /were /being followed. During an interview on 2/24/26 at 12:56 p.m., TMA-D /stated /he /had recently had education and competency testing provided by one of the LPNs to ensure he know how to pass medications correctly. He did not recall exactly what kind of education /he had received. TMA-D was able to name five of the seven rights of /medication /administration, however, /was /not /aware of "right rationale or right /documentation" /being /part of the rights of medication administration. During an interview on 2/24/26 at 2:11 p.m., TMA-B /stated /she had recently received education on the rights of /medication /administration and had competency /done by the administrator. /TMA-B /stated /she did not recall exactly what the education was /about, /but /believed it was /just about how /the process of /doing the medication pass correctly and making sure we are doing /all of /the steps correctly. During an interview on 2/24/26 at 4:52 p.m., administrator /stated /she was not a licensed nurse, however, had /completed some of the /staff medication administration competencies /and education even thought she had not had /any formal /training /on medication administration or the rights of medication administration /to /be able to /determine /if staff were deemed /competent /doing a medication pass. During an interview on 2/24/26 at 4:52 p.m., /DON /stated /she had not performed any of /the /medication administration /training or /competencies /done with staff. She had /a few /staff /deemed /competent by a registered nurse, but /most of /the staff /had been completed by the administrator /(who was not a licensed nurse /nor had /any /education on medication administration) /or by /a /licensed practical nurse. DON /stated /the competencies/education that had been completed by /administrator, /or the /LPNs /would not be considered valid, /due to those staff not having the capability to /determine /competency of the staff or provide education. DON /stated /the /staff that /were /responsible for medication /administration /should have had	F0760		

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F0760 SS = G	Continued from page 28 their /competencies /and/or education /done /by a registered nurse /only. R12's face sheet dated 2/27/26, /identified /diagnoses of heart failure and /gastroesophageal reflux disease. During an observation /and interview /on 2/25/26 at 7:52 a.m., registered nurse (RN)-B prepared medications for R12 by verbalizing and comparing the order to the medication package label. RN-B walked to R12 and verified R12's identity with name and date of birth and compared image of R12 in the electronic health record (EHR). RN-B then informed R12 what each medication was and then handed R12 a liquid oral antifungal /in a small cup, instructed R12 to swish the medication in his mouth then spit the medication out. RN-B then realized the medication was supposed to be a swish and swallow versus a swish and spit. RN-B /stated /she must have misread the order as a /swish and spit verses a swish and swallow and this would be a medication error. /RN-B /stated /she had /a "kind of audit" done recently by the /administrator /while she passed /medication /to ensure she was doing them correctly. RN-B did not recall getting any recent education on the rights of medication administration. R5's face sheet dated 2/27/26, /identified /diagnoses of heart failure, /Parkinson's /disease, and dementia. R5's quarterly MDS dated 12/3/25, /identified /R5 /had intact cognition, /no behaviors, took an antianxiety medication, and received hospice services. R5's physician orders dated 1/30/26, /identified /an order for Lorazepam (anti-anxiety) give 1 mg three times per day for anxiety. R5's Medication Error Incident /Report dated 2/21/26, /identified /R5 received an extra dose of Lorazepam at 4:45 p.m. During an interview on 2/26/26 at 2:28 p.m., TMA-C /stated /she had /a recent medication pass audit and competency test given by the /administrator /along with education on the rights of medication administration. However, despite the education she had made a medication error on 2/21/26 when she gave R5 a extra dose of Lorazepam on 2/21/25. /TMA-C explained she had thought R5 had orders for an as needed dose but did not verify R5's physician orders prior to administering the dose of Lorazepam on 2/21/26 at 4:45 p.m. TMA-A /stated /she should have ensured the rights of medication administration were done prior to administering R5's medication, and if /she /had /followed the rights of medication administration she would not have /made R5's medication /error. TMA-C recited the rights of medication and identified R5's medication error was the result of not administering the right dose of medication. /TMA-C /indicated she has continued to pass medications even though she had not received any	F0760		

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F0760 SS = G	Continued from page 29 re-education since the error was made on 2/21/26. TMA-C explained the DON would be providing education on a later date. During an interview on 2/25/26 at 2:59 p.m., DON stated R5's medication error on 2/21/26 was due to TMA-C not performing the rights of medication not being followed and therefore an error happened that had the potential of being a significant error in certain residents. DON /stated /she had not given TMA-C formal re-education on the rights of medication administration but was planning /on doing /it "soon". Review of the facility's Administering Medications Policy dated 2/26, /identified /the following: -The individual administering medications verifies the resident's identity before giving the resident /his/her /medications. Methods of /identifying /the residents include: a. checking identification /band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right /time /and right method (route) of administration before giving the medication.	F0760		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F0842	F842 Identified Issue Medical Record for resident R1 was not complete for vital sign documentation. Licensed staff not completing the documentation was re-educated by the Director of Nursing on 2/18/2026. Identification of other residents An audit was completed on residents that have a change of condition or have had significant events. Areas reviewed were vitals. Provider notification Any discrepancies identified were corrected promptly. Systemic Changes	04/02/2026

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F0842 SS = D	Continued from page 30 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 30 The Director of Nursing/ Designee performed a nurses meeting re-educating the licensed nurses on 3/26/2026. Licensed nursing staff were re-educated on 3/26/2026 regarding: Complete and timely documentation requirements Documentation of assessments, interventions, and resident response Documentation expectations during significant events and change of condition Facility policy related to clinical documentation A standardized documentation expectation was reinforced for all significant events to ensure consistency. The Director of Nursing/designee will conduct routine audits of overall medical record completeness, not limited to vital signs. Monitoring The Director of Nursing/Designee will conduct: 3 resident record reviews/ week/ x 4 weeks and then 3 records/ month x 3 months Results of the audits to be reported to QAPI for review and any further recommendations. Compliance 3/31/2026	

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F0842 SS = D	Continued from page 31 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 1 of 1 (R1) resident reviewed for significant medication error. Findings include: R1's face sheet dated 2/27/26, identified diagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners). R1's Admission Minimum Data Set (MDS) dated 2/13/26, identified R1 had moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant. R1's progress note dated 2/13/26 at 7:35 a.m., identified nurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident's medication by mistake. Nurse called the on-call physician to inform of the medications had R1 received and was instructed to monitor residents for any adverse reactions to any of the medications. R1's Medication Error incident report dated 2/13/26, identified R1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for evaluation. R1's progress note dated 2/13/26 at 9:20 a.m., identified nurse was called into R1's room by nursing assistant because R1 became unresponsive. R1 was lying with eyes closed, did not respond to verbal commands. "Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace." Blood pressure 137/82 (according to the Mayo Clinic normal blood pressure is under 120/80) and heart rate 92 (according the Mayo Clinic a normal heart rate is 60-100), respirations 18 (according to the Mayo	F0842		

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F0842 SS = D	Continued from page 32 Clinic normal respirations 12-18), oxygen saturations 97% (according to the Mayo Clinic normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED). During an interview on 2/24/26 at 1:44 p.m., licensed practical nurse (LPN)-B stated she had been working on 2/13/26 when R1 received R2's medication. LPN-B stated she had taken R1's vital signs multiple times during her assessments after the medication error, however, did not enter the vital signs in R1's electronic health record (EHR) or any assessments LPN-B had completed on R1. During an interview on 2/24/26 at 4:52 p.m., director of nursing (DON) stated LPN-B should have included each set of vital signs values along with assessments in R1's EHR that she had completed to ensure R1's record was complete and accurate. DON explained that her expectation would be for all licensed staff to ensure the documentation was complete prior to the end of their shift. DON added, "If it is not documented, then it was not done." Review of the facility's Charting and Documentation Policy dated 3/26, identified that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation as follows:The following information is to be documented in the resident medical record:Objective observations.Medications administered.Treatments or services performed.Changes in the residents' condition.Events, incidents, or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.2. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 3. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the residents' medical chart as permitted by facility policy. 4. Documentation of procedures and treatments will include care-specific details, including:the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care.the assessment data and/or any unusual findings obtained	F0842		

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F0842 SS = D	Continued from page 33 during the procedure/treatment.how the resident tolerated the procedure/treatment.whether the resident refused the procedure/treatment.notification of family, physician, or other staff, if indicated; andthe signature and title of the individual documenting..	F0842		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic	F0867	F 867 Identified issue The facility QAPI reviewed by the Administrator and Director of Nursing Completion of root cause analysis on high-risk issues to include but not limited to: Infection control Medication management Skin integrity Falls Identified other areas Completion of meeting minutes Follow up to data System changes The facility has been restructured and strengthened the QAPI Program Monthly meeting with accurate meeting minutes Develop and implement performance improvement projects based on identified high risk, high volume or other areas identified by the committee A standardized process for tracking, trending and sustaining improvements	04/02/2026

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F0867 SS = F	Continued from page 34 action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or	F0867	Continued from page 34 Education Roles and responsibilities in the QAPI process Ongoing education will be provided to ensure staff participation and understanding of QAPI Monitoring Administrator/Designee will monitor QAPI compliance through: Monthly review of meeting minutes Verification of Performance Improvement Projects Audits 1 X per month for 3 months Quarterly for 1 year Completion 3/27/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0867 SS = F	Continued from page 35 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded high risk issues related to a falls, medication errors, and pressure ulcers by developing and implementing action plans for process improvement. This deficient practice had the potential to affect all 36 residents that resident in the facility. Findings include: SEE F689: Based on observation, interview and document review the facility /failed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4, R9) reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed to /comprehensively investigate/analyze falls for root cause, implement /appropriate interventions /to prevent and/or reduce the risk for future falls /for 1 of 3 residents (R3) reviewed for falls/safety.	F0867		

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F0867 SS = F	Continued from page 36 SEE F760: Based on interviews and document review the facility failed to ensure that 1 of 1 resident (R1) was free of a significant medication error by not observing the rights of medication administration. This caused actual harm for R1 when she was administered another resident's medication became unresponsive and had to be hospitalized for hypotension and developed an acute kidney injury. SEE 686: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers to prevent deterioration for 3 of 3 residents (R10, R4, R9) reviewed for pressure ulcers. /This resulted in actual harm for R10 who developed a stage 2 pressure ulcer on her sacrum that deteriorated to a stage 3 pressure ulcer. Review of QAPI data from May 2025 through January 2026 identified across all months the facility consistently collected and reported data related to falls, pressure ulcers, and medication errors; however, the documents did not address or include root cause analysis, prioritization of high-risk or recurring issues, development of performance improvement projects, implementation of corrective actions, and monitoring of interventions for effectiveness. Quality documents included the following:May 2025: 5 falls; 3 residents with stage 3 pressure ulcer with no documentation if facility acquired or admitted with; no documentation of medication errors. No documented discussion or action plans.June 2025: No fall data documented; 2 residents with Stage 1 pressure ulcers with no documentation if facility acquired or admitted with; one medication error. No documented discussion or action plans.July 2025: 6 falls with no injury; 2 pressure ulcers (Stage 1 and Stage 2) with no documentation of facility acquired or admitted with; no medication errors. No documented discussion or action plans.August 2025: 8 falls (1 with injury); 1 healed facility acquired pressure ulcer.September 2025: 9 falls with one with injury. Comment added that one fall with major injury/hip fracture; 2 pressure ulcers (Stage 1 and unstageable/DTI), no indication if facility acquired.; one medication error. No documented discussion or action plans.October 2025: 7 falls; no pressure ulcer data; one medication error. No documented discussion or action plans.November 2025: 8 falls (1 with injury); 3 pressure ulcers (Stage 1, Stage 2, unstageable/DTI), no indication if facility acquired; one medication errors No documented discussion or action plans.December 2025: 7 falls (1 with injury); spreadsheet did not identify	F0867		

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F0867 SS = F	Continued from page 37 that the fall with injury involved a mechanical lift; pressure ulcers; no medication errors. No documented discussion or action plans.January 2026: 8 falls (no injury); 3 Stage 2 pressure ulcers and 1 unstageable/DTI; no indication if facility acquired; no medication errors. No documented discussion or action plans.During an interview on 2/26/26 at 4:26 p.m., medical director (MD) stated she was part of the QAPI committee and attends the meetings monthly. MD was unaware of any current action plans that had been put in place by the committee to ensure falls, wounds, or medication errors had been addressed. During an interview on 3/2/26 at 4:39 p.m., administrator stated the facility's QAPI committee meets monthly to bring forward data such as wounds, falls, and medication errors. The facility had identified a current issue in each of these areas after review of incident reports and wound documentation, however, had not created an action plan to improve quality in any of the areas but only reviewed the data. The administrator stated she was the QAPI committee chairperson who would be responsible for ensuring adverse outcomes are identified, a discussion with the committee, and action plans put in place to attempt/reduce further adverse outcomes. Administrator explained that the QAPI committee had not taken any minutes regarding any discussions during the last four quarters, so therefore had not had any discussion from previous months to review, analyze, and respond to the issues brought forth in the QAPI meetings. The administrator stated, "The facility does a great job collecting data, however, does not do a great job with what we do with the data." Review of the Review of the facility's Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Plan dated 11/25/25, identified the following: The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents, caregivers and other partners so that we may realize our mission. To do this, all employees will participate in ongoing QAPI efforts which support our mission. Feedback, Data Systems, and Monitoring: -The facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from	F0867		

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F0867 SS = F	Continued from page 38 staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences. Performance Improvement Projects: -The QAPI team at St. Mark's Living will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements. -Based on the result of the review of information, the QAPI team will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI team will determine which problems will become the focus for a performance improvement project (PIP).	F0867		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/20/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 3/2/26 a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		03/18/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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20000	Continued from page 1 The following complaints were reviewed. H53692080C (2699728), H53696441C (2745221 and 2745648) with a licensing order issued at 255, 625, 830, 900,1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.	20000		
20255	Quality Assessment and Assurance Committee CFR(s): MN Rule 4658.0070 A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded high risk issues related to a falls, medication errors, and pressure ulcers by developing and implementing action plans for process improvement. This deficient practice had the potential to affect all 36 residents that resident in the facility. Findings include	20255	corrected	04/02/2026

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20255	Continued from page 2 SEE F689: Based on observation, interview and document review the facility /failed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4, R9) reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed to /comprehensively investigate/analyze falls for root cause, implement /appropriate interventions /to prevent and/or reduce the risk for future falls /for 1 of 3 residents (R3) reviewed for falls/safety. SEE F760: Based on interviews and document review the facility failed to ensure that 1 of 1 resident (R1) was free of a significant medication error by not observing the rights of medication administration. This caused actual harm for R1 when she was administered another resident's medication became unresponsive and had to be hospitalized for hypotension and developed an acute kidney injury. SEE 686: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers to prevent deterioration for 3 of 3 residents (R10, R4, R9) reviewed for pressure ulcers. /This resulted in actual harm for R10 who developed a stage 2 pressure ulcer on her sacrum that deteriorated to a stage 3 pressure ulcer. Review of QAPI data from May 2025 through January 2026 identified across all months the facility consistently collected and reported data related to falls, pressure ulcers, and medication errors; however, the documents did not address or include root cause analysis, prioritization of high-risk or recurring issues, development of performance improvement projects, implementation of corrective actions, and monitoring of interventions for effectiveness. Quality documents included the following:May 2025: 5 falls; 3 residents with stage 3 pressure ulcer with no documentation if facility acquired or admitted with; no documentation of medication errors. No documented discussion or action plans.June 2025: No fall data documented; 2 residents with Stage 1 pressure ulcers with no documentation if facility acquired or admitted with; one medication error. No documented discussion or action plans.July 2025: 6 falls with no injury; 2 pressure ulcers (Stage	20255		

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20255	Continued from page 3 1 and Stage 2) with no documentation of facility acquired or admitted with; no medication errors. No documented discussion or action plans.August 2025: 8 falls (1 with injury); 1 healed facility acquired pressure ulcer.September 2025: 9 falls with one with injury. Comment added that one fall with major injury/hip fracture; 2 pressure ulcers (Stage 1 and unstageable/DTI), no indication if facility acquired.; one medication error. No documented discussion or action plans.October 2025: 7 falls; no pressure ulcer data; one medication error. No documented discussion or action plans.November 2025: 8 falls (1 with injury); 3 pressure ulcers (Stage 1, Stage 2, unstageable/DTI), no indication if facility acquired; one medication errors No documented discussion or action plans.December 2025: 7 falls (1 with injury); spreadsheet did not identify that the fall with injury involved a mechanical lift; pressure ulcers; no medication errors. No documented discussion or action plans.January 2026: 8 falls (no injury); 3 Stage 2 pressure ulcers and 1 unstageable/DTI; no indication if facility acquired; no medication errors. No documented discussion or action plans.During an interview on 2/26/26 at 4:26 p.m., medical director (MD) stated she was part of the QAPI committee and attends the meetings monthly. MD was unaware of any current action plans that had been put in place by the committee to ensure falls, wounds, or medication errors had been addressed. During an interview on 3/2/26 at 4:39 p.m., administrator stated the facility's QAPI committee meets monthly to bring forward data such as wounds, falls, and medication errors. The facility had identified a current issue in each of these areas after review of incident reports and wound documentation, however, had not created an action plan to improve quality in any of the areas but only reviewed the data. The administrator stated she was the QAPI committee chairperson who would be responsible for ensuring adverse outcomes are identified, a discussion with the committee, and action plans put in place to attempt/reduce further adverse outcomes. Administrator explained that the QAPI committee had not taken any minutes regarding any discussions during the last four quarters, so therefore had not had any discussion from previous months to review, analyze, and respond to the issues brought forth in the QAPI meetings. The administrator stated, "The facility does a great job collecting data, however, does not do a great job with what we do with the data." Review of the Review of the facility's Quality Assessment and Assurance/Quality Assurance Performance	20255		

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20255	Continued from page 4 Improvement (QAA/QAPI) Plan dated 11/25/25, identified the following: The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents, caregivers and other partners so that we may realize our mission. To do this, all employees will participate in ongoing QAPI efforts which support our mission. Feedback, Data Systems, and Monitoring: -The facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences. Performance Improvement Projects: -The QAPI team at St. Mark's Living will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements. -Based on the result of the review of information, the QAPI team will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI team will determine which problems will become the focus for a performance improvement project (PIP). SUGGESTED METHOD OF CORRECTION: The QAPI committee should review and/or revise QAPI policies and procedures to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes for care and quality of life. Data brought forth should have meaningful review of each area noted. QAPI should identify benchmarks and goals, and review data to identify trends, create action plans to achieve their goals, and to monitor facility progress. QAPI should then report those efforts to the Governing Body to monitor for compliance. The administrator will be	20255		

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20255	Continued from page 5 responsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20255		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings;	20625	corrected	04/02/2026

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20625	Continued from page 6 K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 1 of 1 (R1) resident reviewed for significant medication error. Findings include: R1's face sheet dated 2/27/26, identified diagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners). R1's admission Minimum Data Set (MDS) dated 2/13/26, identified R1 had moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant. R1's progress note dated 2/13/26 at 7:35 a.m., identified nurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident's medication by mistake. Nurse called the on-call physician to inform of the medications had R1 received and was instructed to monitor residents for any adverse reactions to any of the medications. R1's Medication Error incident report dated 2/13/26, identified R1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for	20625		

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20625	Continued from page 7 evaluation. R1's progress note dated 2/13/26 at 9:20 a.m., identified nurse was called into R1's room by nursing assistant because R1 became unresponsive. R1 was lying with eyes closed, did not respond to verbal commands. "Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace." Blood pressure 137/82 (according to the Mayo Clinic normal blood pressure is under 120/80) and heart rate 92 (according the Mayo Clinic a normal heart rate is 60-100), respirations 18 (according to the Mayo Clinic normal respirations 12-18), oxygen saturations 97% (according to the Mayo Clinic normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED). During an interview on 2/24/26 at 1:44 p.m., licensed practical nurse (LPN)-B stated she had been working on 2/13/26 when R1 received R2's medication. LPN-B stated she had taken R1's vital signs multiple times during her assessments after the medication error, however, did not enter the vital signs in R1's electronic health record (EHR) or any assessments LPN-B had completed on R1. During an interview on 2/24/26 at 4:52 p.m., director of nursing (DON) stated LPN-B should have included each set of vital signs values along with assessments in R1's EHR that she had completed to ensure R1's record was complete and accurate. DON explained that her expectation would be for all licensed staff to ensure the documentation was complete prior to the end of their shift. DON added, "If it is not documented, then it was not done." Review of the facility's Charting and Documentation Policy dated 3/26, identified that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation as follows:The following information is to be documented in the resident medical record:Objective observations.Medications administered.Treatments or services performed.Changes in the residents' condition.Events, incidents, or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.2. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.	20625		

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20625	Continued from page 8 3. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the residents' medical chart as permitted by facility policy. 4. Documentation of procedures and treatments will include care-specific details, including:the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care.the assessment data and/or any unusual findings obtained during the procedure/treatment.how the resident tolerated the procedure/treatment.whether the resident refused the procedure/treatment.notification of family, physician, or other staff, if indicated; andthe signature and title of the individual documenting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility /failed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4 and R9)	20830	corrected	04/02/2026

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20830	Continued from page 9 reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed to /comprehensively investigate/analyze falls for root cause, implement /appropriate interventions /to prevent and/or reduce the risk for future falls /for 1 of 3 residents (R3) reviewed for falls/safety. The IJ began on /2/25/26, /when nursing assistant (NA)-C and NA-D had to be stopped from using the wrong harness size according to R4's care plan and the failed to follow manufacturer's instructions to tighten the harness torso strap to ensure safety putting R4 at likelihood for serious harm/injury or death. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 2/26/26 at 6:08 p.m. The immediate jeopardy was removed on /3/2/26 at 2:30 p.m., /but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated 12/23/25, indicated R4 did not have cogntive impairment, had no behaviors, no rejection of care, no range of motion limitations on upper or lower extremities, was dependent for sit to stand, and was dependent on staff for chair to bed transfer. Additionally, R4 had a fall in the last month prior to facility admission, had a fall within the last 2-6 months since admission with no injury, and had one fall since admission with injury. R4's Morse Fall Scale (a tool used to determine risk of falling) dated 12/18/25, identified R4 as a high-risk for falling due to weakness and history of falling. R4's Therapy Recommendation form dated 12/18/25, identified R4 needed assistance of two staff with the sit-to-stand mechanical lift for all transfers with large harness due to needing cues for hand placement. R4's fall focus care plan dated 12/27/25, identified R4 was at risk for falls related to history of falls before and after admission. Goal to be free from falls. Interventions dated 12/18/25 as follows: -Call light within reach. Encourage use of call light for assistance as needed. -Ensure resident is wearing appropriate footwear (non-skid socks or rubber soled shoes) during transfer, ambulation and/or mobilizing in wheelchair. -In the event of	20830		

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20830	Continued from page 10 fall, resident will need assistance of two staff with a total mechanical lift and a large sling. -Routine safety checks. -Follow facility fall protocol. R4's Activity of Daily Living (ADL) focus care plan initiated on 12/18/25, identified R4 had an ADL self-care performance deficit related to weakness, history of stroke, cancer of the pancreas, and diabetic with neuropathy (damage to the nerves resulting in pain, numbness, tingling, or weakness especially in the hands and feet). Goal to improve current level of function in ADLs. Interventions dated 12/19/25 directed staff for toilet use: R4 required assistance from two staff for all transfers with a sit to stand mechanical lift and for transfers R4 required assistance from two staff members for "all transfers." R4's nurse aide resident care sheet dated 12/21/26, identified R4 needed assist of two staff with the sit-to-stand mechanical lift with a large harness. During an interview on 2/25/26 at 7:45 a.m., trained medication aide (TMA)-B explained staff would use the therapy recommendation or the paper care sheet (not the care plan or kardex (abbreviated care plan)) to determine what size harness a resident required when using the sit-to-stand lift. R4's progress note dated 12/21/25 at 1:56 p.m., identified the nurse was called to R4's room and found that R4 had fallen from the sit-to-stand mechanical lift. R4 was lying on the floor with his feet still on the sit-to-stand with the leg strap still buckled and his head resting on the recliner. "Isolated incident care plan was not followed by nursing assistant and was transferred by one person using the sit-to-stand mechanical lift." Noted a friction bruise that was reddish in color under left armpit from the sling. R4 was changed to a total mechanical lift until therapy can re-assess. Educated staff on importance of following care plan and two staff for cares and transfers. R4's record did not identify the size of sling used and not evident a comprehensive assessment was completed to determine sling size for the full body mechanical. Additionally, the care plan was not revised to include intervention(s) for R4 falling asleep in the lift. R4's fall incident report dated 12/21/25 at 12:23 p.m., identified R4 had a witnessed fall from the sit-to-stand mechanical lift. /Writer witnessed the patient lying on the floor with his feet still in the /sit-to-stand mechanical lift /with leg strap still buckled, head propped up on the footrest of the recliner, which was down at the time. /Resident description was that R4 felt weak and let go of the /sit-to-stand mechanical lift /and his arms went up and he fell. R4's Fall Root Cause Analysis and Witness Statement form dated 12/21/25, identified R4 was supposed to have two staff members for all transfers	20830		

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20830	Continued from page 11 with the sit-to-stand however, according to witness statement the nursing assistant attempted transfer by herself from wheelchair to the recliner while R4 fell asleep during transfer and fell. R4 felt weak and arms went up when he let go of the sit to stand mechanical lift and fell. During an interview on 2/26/26 at 11:06 a.m., nursing assistant (NA)-E stated on 12/21/26, R4 had asked for a brief change and wanted to be transferred from his wheelchair to his recliner. NA-E stated she was aware R4 needed two staff to transfer using the sit-to-stand mechanical lift, so she had requested assistance over the walkie talkie but did not get a response. NA-E stated she had not verified R4's care plan/care sheet and/or therapy sheet to see what size sit-to-stand harness R4 was supposed to use. NA-E stated with conviction she was "100% positive she used an extra-large [XL] harness to transfer R4, because R4 was the only resident using the sit to stand lift in that unit and staff kept the sling at all times on the lift." NA-E then proceeded to transfer R4 by herself. NA-E stood R4 in the sit-to-stand mechanical lift, performed pericare as R4 stood up, pulled R4's pants back up, and then turned and then pushed the lift towards the recliner. Once in front of the recliner R4 began to fall asleep, he let go causing him to slip completely out of the lift harness onto the ground. Review of the facility investigation notes identified NA-E was not contacted until 12/22/25 by an unknown staff member. On 12/22/25 NA-E stated she was aware R4 needed assist of two staff with the sit to stand lift, but other staff were busy, so she needed to get R4 cleaned up and moved. NA-E informed DON she had checked R4's care plan and verified harness size (notes did not identify what size harness NA-E used at the time of the transfer), attached the harness and buckled R4's feet and decided to then lift R4 up in the lift. NA-E cleaned and changed R4's pad and then was going to transfer R4 to the recliner but when NA-E was positioning R4 near the recliner, R4 slipped out, fell to the ground. R4 told NA-E he had fallen asleep and she then called the nurse. During an interview on 2/26/26 at 12:02 p.m., licensed practical nurse (LPN)-C stated on 12/21/25 at around 12:30 p.m. she had been called to R4's room by NA-E over the walkie talkie to report R4 had fallen from the lift. Upon entering R4's room she found R4 sitting on the floor in front of his recliner with both of his legs still resting on the lifts' foot plate with the calf strap still buckled. The harness was still connected to the lift with the torso strap still buckled; the harness was connected to the lift appropriately. LPN-C had not verified that R4's harness was the correct size after the fall, "I did not even think to check." LPN-C explained she thought R4 fell	20830		

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20830	Continued from page 12 out of the lift because NA-E had not cinched the torso strap tight so when R4 let go he slipped completely out of the harness. LPN-C further stated R4 had pain in his left shoulder for some time after the fall which was treated with pain cream. During an interview on 2/26/26 at 12:44 p.m., the Director of Nursing (DON) stated she was notified on 12/21/25 that R4 had fallen from the sit to stand lift. Following the notification, the DON immediately removed NA E from the work schedule. She reported attempting to interview NA E shortly after the incident but was unable to reach her at that time. DON returned to the facility later that afternoon, inspected the lift and harness, and noted no apparent defects. She reported she was not aware that an XL harness had been used during the transfer; she believed a large sling had been used but had no documentation verifying the harness size at the time of the fall. DON interviewed NA E on 12/22/25. During that interview, NA E reported she had transferred R4 alone and did not utilize a second staff member as required by policy and the resident's care plan. NA E had stated that R4 fell asleep during the transfer, released her hold on the equipment, and subsequently slipped out of the sling. DON reported she did not recreate the incident with NA E to determine the cause of the fall and did not have documentation of any post incident inspection of the lift or harness. DON kept NA E off the schedule until NA E completed a repeat competency test on the safe use of mechanical lifts. DON reported conducting multiple competencies and audits on NA E only and acknowledged she did not perform audits or provide additional staff education regarding adherence to care plans for any other staff members. DON stated she did not believe improper lift use was a systemic issue and therefore limited education and competency review to NA E. R4's progress note dated 12/22/25, identified R4 was complaining left shoulder was sore. R4 pointed to left shoulder and had an "ache" and with range of motion (ROM) had pain. R4 was seen by nurse practitioner virtually and no x-ray ordered. R4's nurse practitioner note dated 12/22/25, identified R4 was seen due to pain in left shoulder following a fall from the sit-to-stand mechanical lift on 12/21/25. Physician order for /Voltaren (pain cream)1% gel; Apply 2 g topically 4 (four) times a day. May also apply 2 grams four times a day as needed (shoulder pain). R4's Medication Administration Record (MAR) reviewed 12/23/25 through 1/5/26 identified Voltaren cream had been applied to R4's left shoulder 14 times. R4's care plan revised on 2/24/26, identified R4 required assistance from two staff using sit-to-stand mechanical lift. R4's resident care guide reviewed on 2/25/26, identified R4	20830		

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20830	Continued from page 13 needed assist of two staff with sit-to-stand mechanical lift with a large harness. During an observation and interview on 2/25/26 at 9:31 a.m., NA-C and NA-D entered R4's room to assist R4 with transfer from bed to shower chair. NA-D brought in a sit-to-stand mechanical lift with a harness draped over the top of the lift. NA-D stated R4 was the only resident on the wing that used the sit-to-stand lift and that his (XL) harness was draped over the lift. NA-D stated twice the XL was the correct size for R4. NA-C and NA-D then sat R4 at the edge of the bed and placed the XL harness behind R4's back. Surveyor intervened and asked NA-C and NA-D to verify that the XL harness size was the correct size to use with R4. Neither NA-C nor NA-D had a resident care guide that identified R4's correct harness size. NA-D left the room to find out the correct harness size R4 was supposed to use and returned to R4's room with a large harness. NA-D stated she verified R4's resident care guide and it identified R4 was to use a large harness not an XL. NA-D stated she had to go to another wing in the building to find the correct harness size for R4, because the size was not in R4's unit. Registered nurse (RN)-A then entered R4's room and stated R4 had been assessed by therapy and was suppose to be using a large harness, RN-A stated R4's care plan/kardex did not identify harness size , but the resident care guide did specify the correct size and staff should be checking in all places to verify they are using the correct harness. NA-C and NA-D then placed the large harness behind R4's back, applied the loops, provided cues to have proper hand placement to R4, attached the leg and torso strap, had R4 stand. As R4 stood, NA-C nor NA-D cinched the torso strap. Surveyor intervened to instruct NA-C and NA-D to cinch the torso strap as R4 stood. NA-C stated she was aware the torso strap needed to be cinched as a resident stands up, but must have just overlooked doing it. NA-C stated a resident could fall out of the lift if this is not done each time they stand up and she should have made sure this was done. NA-C and NA-D stated they had not received any re-education on the proper use of mechanical lifts nor following care plan since their initial orientation. During an interview on 2/25/26 at 10:30 am., director of nursing (DON) verified R4's care plan/Kardex did not identify R4's harness size staff are supposed to use during a transfer with a sit to stand lift. DON stated R4 was supposed to be using a large harness and it had been identified on the resident care sheet, but should have been added to the care plan/Kardex. DON stated staff were supposed to use the Kardex and/or resident care guides to verify correct harness size prior initiating a transfer with the lifts. During an interview on 2/26/26 at 4:26 p.m., medical director	20830		

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20830	Continued from page 14 (MD) stated any resident being transferred using a mechanical lift without a care plan and/or policy followed for use of the mechanical lift had the likelihood to cause serious harm, serious injury, or even death in the event the resident falls from the mechanical lift. R9 R9's face sheet dated 3/1/26, identified R9 had diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's Significant Change MDS dated 1/26/26, identified R4 was cognitively intact, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was dependent for chair/bed to chair transfers. R9's Mechanical Lift Sling/Harness Sizing Assessment dated 2/27/26, identified R9 needed a large sling for the total mechanical lift. R9's ADL focus care plan dated 5/21/25, identified R9 had a self-performance deficit related to weakness, chronic respiratory failure, and schizophrenia. Goal to maintain current level of functioning. Interventions as follows for transfers: -EZ stand harness size large (R9 did not use an EZ stand lift); Total mechanical lift sling: (was left blank). Dated 2/27/26. -Transfer: The resident requires total dependence on two staff for transferring via total mechanical lift with an XL sling. Dated 1/8/26. R9's Kardex reviewed on 3/2/26 at 10:00 a.m., identified R9 needed a XL sling for with the total mechanical lift, however, this conflicted with the assessment dated 2/27/26 that identified R9 required a large sling. During an interview on 3/2/26 at 10:14 a.m., DON reviewed and verified R9's care plan/Kardex conflicted with the assessment dated 2/27/26. DON confirmed R9 had been measured and assessed for proper sling size on 2/27/26, determined he needed a large sling verses an XL sling. DON was not aware R9's care plan/Kardex had not been updated to reflect the correct sling size of a large sling. During an observation and interview on 3/2/26 at 10:39 a.m., R9 was seated in wheelchair on top of mechanical lift sling that was in color with green trim. Trained medication aide (TMA)-C entered R9's room and stated that she was unable to verify what size R9's sling by the tag, due to the sizing being washed off. TMA-C stated a tan sling with green trim would be an /XL /sling. TMA-C then walked to a mechanical lift, identified the sling color with the coding sizing chart on the front of the lift that indicated a green trim sling was indeed an /XL /sling. TMA-C then verified on R9's Kardex that R9 was supposed to be in a large sling and not an XL sling during transfers using the total mechanical lift. TMA-C stated, "R9 could have fallen out of that sling, and we are lucky he did not." During an interview on 3/2/26 at 11:03 a.m.,	20830		

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20830	Continued from page 15 DON stated NA-D informed her that she had not transferred R9 using the correct sling size, NA-D had only verified the sling size by using the paper nurse aide care guide. DON explained using the sling that was too large could have caused R9 to fall out of the sling during a transfer. DON and TMA-C then removed the incorrect sling out from under R9 and placed the correct size sling in R9's room to be used for the next transfer. DON stated R9's care plan had been amended to remove any XL sling off his care plan and the paper care sheets removed off the floor to ensure staff were checking the same place to verify correct sling sizes for any residents that need to transferred using any mechanical lift. The immediate jeopardy that began /on 2/25/25 was removed on 3/2/26 at 2:30 p.m., when it was verified, the facility implemented the following: - The facility has identified all those that use a sit to stand. The facility has assessed each resident and the size of harness needed. The facility educated each member of the nursing staff that will or had potential to use the sit to stand. - R4 and all residents using mechanical lifts were assessed for: Proper transfer method Correct sling/harness size Care plan accuracy. - Sling/harness size was verified for each resident through: Therapy documentation Direct measurement Manufacturer guidelines Care plan accuracy. -Systemic Corrections Policy Review Mechanical lift transfer policy reviewed and updated to: Require sling/harness size documented in care plan and Kardex. Require 2-assist transfers when indicated. Require staff verification of sling size prior to transfer. Require cinching of waist/middle straps before elevation. Documentation Care plans updated to specifically identify: Type of lift Assist level. Sling/harness size. Kardex updated to match care plan. Care sheets updated to match the care plan -Education All licensed nurses and other certified individuals: Manufacturer recommendations Proper sling application Proper strap placement and cinching When sit-to-stand lifts are contraindicated. Always following care plan Education included: In-service training Hands-on demonstration Return competency validation. Competency Quiz Review of the facility's Mechanical Lift Policy dated 12/25, identified it is the policy to lift and move a resident safely without causing serious injury to staff or residents. Procedure as follows: -All mechanical lifts require two staff for operation. -All staff will be trained on proper lift use prior to operating mechanical lifts. -Lifts will be inspected per manufacturer's recommendations. -Lift slings are inspected by nursing prior to use and by laundry when washed. -Inspections will be audited and	20830		

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20830	Continued from page 16 reviewed and monthly safety meetings. R3 R3's face sheet dated 2/27/26, identified diagnoses of malignant neoplasm of the brain, heart failure, and osteoporosis. R3's significant change MDS dated 2/16/26, identified moderate cognitive impairment, no behaviors, no rejection of care, used a walker and wheelchair, needed partial/moderate assistance for transfers, had one fall with no injury and one fall with injury since admission. R3's fall focus care plan initiated on 1/9/26, identified R3 was at risk for falls related to limited mobility, communication issues, and weakness. Goal to be free from falls. Interventions as follow: -Follow facility fall protocol. -Routine safety checks. Start date 1/9/26. -Anticipate and meet the resident's needs. Start date 1/9/26. -PT evaluate and treat as ordered. Start date 1/9/26. -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes. Start date 1/9/26. -Be sure the residents' call light is within reach and encourage the residents to use it for assistance as needed. The resident need prompt response to all requests for assistance. R3's fall incident report dated 2/10/26 at 1:40 p.m., identified R3 had an unwitnessed fall in the bathroom after being assisted by a family member and being alone for a minute. R3 attempted self-transfer and fell on her buttocks. Family member assisted R3 off the floor and reported the fall to staff. R3's Incident Root Cause Analysis Worksheet dated 2/10/26, identified problem that R3 was left unattended while in the bathroom. Root cause of fall was left blank. /There was no /indication /of a comprehensive analysis to /identify /potential causal factors. R3's fall focus care plan was revised on 2/11/25 to encourage family members not to transfer resident and to ask for staff for assistance. R3's fall incident report dated 2/18/25 at 1:50 a.m., identified R3 was on the bathroom floor with her walker located outside of the bathroom door. Predisposing physiological factors of weakness, gait imbalance, drowsy. Predisposing situation factors of ambulating without assist devices. /R3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls. R3's Incident Root Cause Analysis Worksheet dated 2/18/26, identified a problem that R3 self-transfers at times without a walker. Root causes of fall identified as brain cancer, weakness, and self-transfers. Although the analysis idetentified potential causal factors, there was no indication of a comprehensive analysis that determined associated interventions that would decrease the risk	20830		

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20830	Continued from page 17 or prevented falls based on the causal factors that were identified. R8's care plan revised on 2/19/26 directed staff to place dycem (anti-slip) mat placed in seat of wheelchair, /however, it could not be determined the rational for placement of the dycem based on the identified causal factors of the fall that were identified on the causal analysis worksheet. R3's fall incident report dated 2/20/26, identified R3 had an unwitnessed fall in her room at 8:05 a.m. R3 was found on the floor lying next to her bathroom. /R3 had independently walked to the bathroom by herself and lost her balance. /R3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls. R3's Incident Root Cause Analysis Worksheet dated 2/20/26, identified R3 was found outside of her bathroom on the floor, visual checks every 30 minutes cannot be done when nursing assistants in rooms providing care (R3's record did not identify 30-minute checks had ever been initiated). Had an inquiry about adding an ultra-low bed. /In review of R3's record although a potential cause was identified there was no indication 30-minute checks had ever been initiated. Additionally even though R3's care plan had been revised 2/25/26 (5 days after the fall) directed staff to check and change every two hours and offer bedpan if the R3 chose, there was no corresponding comprehensive assessment that identified how the frequency and type of toileting program was determined. During an interview on 2/27/26 at 1:16p.m., DON stated R3's falls had been discussed during the IDT daily meetings, however, had not had a comprehensive causal analysis done for each fall to ensure that person-centered interventions were put in place for each fall. DON indicated toileting was the root cause of her falls and should have been addressed before 2/25/26 Review of the facility's Falls-Clinical Protocol dated 2/26, identified the following: Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify potential causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. 2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. /After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. /Many categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling. 3. The staff and physicians will	20830		

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20830	Continued from page 18 continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible, and staff are deemed competent to operator’s instructions. The director of nursing or designee should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	20830		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents at risk for or with pressure ulcers received ongoing comprehensive assessment, individualized reassessment of pressure-relief effectiveness, and revised interventions necessary to prevent deterioration and support healing for /3 /of 3 /residents /(R10, R4, R9) reviewed for pressure ulcers. This resulted in actual harm for R10 who had facility acquired stage 2 pressure ulcer on her left sacral region (buttock) that	20900	corrected	04/02/2026

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20900	Continued from page 19 deteriorated to a stage 3 pressure ulcer. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R10's face sheet dated 3/3/26, identified diagnoses of multiple sclerosis, diabetes, heart failure, neurogenic bladder and bowel, and chronic kidney disease. R10's quarterly Minimum Data Set (MDS) dated 9/18/25, identified R10 was cognitively intact, no behaviors, no rejection of care, had impairment on both lower extremities, used a wheelchair, dependent to roll left and right, dependent for transfers, at risk for pressure ulcers, had no	20900		

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20900	Continued from page 20 unhealed pressure ulcers, no venous/arterial ulcers, had moisture associated skin damage (MASD); used pressure reducing device for chair and bed, was not on a turning and repositioning program, had application of non-surgical dressings other than feet; and application of ointments/medications other than feet. R10's Braden Scale for Predicting Pressure Sore Risk dated 9/18/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions to elevate heels off bed, pressure reducing mattress on bed, pressure reducing pad in chair, turn and reposition while in bed. R10's Activity of Daily Living (ADL) focus care plan dated 9/4/21, identified R10 had a self-care deficit related to multiple sclerosis (MS) and MS complications. Goal to be clean and well groomed. Interventions as follows: -Transfers: dependent on two staff (dated 5/14/25). -Bed mobility: dependent on staff for repositioning and turning in bed (dated 12/16/25). R10's skin integrity focus care plan revision date of 12/16/25, identified R10 had potential/actual impairment to skin integrity with fragile skin related to limited mobility and moisture associated skin damage (MASD). Goal to be free of any skin related infection. Interventions as follows: -Elevate heels off bed (dated 11/24/21). -Skin barrier cream/ointment to protect skin as needed (dated11/24/21). -Pressure reducing pad while in chair (dated 6/21/24). -Have resident lay down one hour every shift to relieve pressure off peri area. Start 4/11/25. -Avoid pulling buttocks open with care and treatment (dated 9/24/25). -Nutrition supplements as ordered for wound healing (dated 9/24/25). -Provide peri care two times per shift on days and evening (dated 9/24/25). -Reposition every hour while in chair (dated 9/24/25). -Turn and reposition while in bed every two hours (dated 9/24/25). Review of R10's Skin Assessments dated 9/19/25, 9/26/25, 10/3/25, 10/10/25, 10/24/25 (completed 14 days after last assessment) identified R10 had redness to bottom/skin breakdown on each of the assessments. R10's assessments did not identify location, measurements, wound type, nor any other wound characteristics. R10's physician orders identified the following: -Wound left buttocks: wash per facility protocol, pat dry, apply zinc oxide (a medical cream to treat skin irritations) ointment twice daily for 14 days; after 14 days apply barrier	20900		

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20900	Continued from page 21 cream to wound until resolved twice daily. Start date 8/15/25 with end date of 11/19/25. R10's Skin Assessment dated 11/7/25, identified left buttocks had "healing popped blisters." Mepilex (foam dressing) had been applied. No other wound characteristics including measurements, wound integrity, and location on the buttock were included. R10's record did not identify a corresponding physician order for the treatment of the foam dressing. However, physician order dated 11/8/25 directed alternating pressure air mattress; a full 30 degrees turns side to side every 2 hours while in bed; reposition every hour while in bed; cushion to chair -such as ROHO (air filled pressure-relief cushion) when in wheelchair; elevate heels while in bed. R10's Skin Assessment dated 11/14/25, identified a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm. R10's assessment did not identify any description of the wound characteristics. Corresponding progress note included a situation, background, assessment, and response (SBAR) had been sent to physician indicating R10 had a stage 2 pressure ulcer on left buttocks that measured 2.0 (cm) x 1.0 cm with partial thickness loss of skin, skin was pink, had a moist wound bed with fragile surrounding skin. No further characteristics was identified. R10's record reviewed 11/14/25 through 11/16/25 did not include an order for wound care treatment for the identified stage 2 pressure ulcer. R10's nurse practitioner note dated 11/17/25, identified R10 had a stage 2 pressure ulcer on her left buttocks that continue to be open despite nursing care. R10 used a ROHO cushion "but unfortunately the ROHO was placed backwards." R10's physician orders /dated 11/17/25, included the following: -Left buttocks wound to wash with wound cleanser, scrub the wound bed, apply Duoderm Signal (a name brand dressing that signals when it is time to be changed) dressing to wound bed, change every 3rd day or as needed if dressing peels off. Start date 11/17/25. -Apply zinc oxide twice daily to skin surrounding left buttocks wound to act as barrier for incontinence. Do not scrub the zinc oxide off but reapply twice a day for incontinence. Start date 11/17/25. R10's Skin Assessments dated 11/21/25, 11/28/25, and 12/5/25, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Braden Scale for Predicting Pressure Sore Risk dated 12/10/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly	20900		

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20900	Continued from page 22 limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions as follows: -Elevate heels off bed. -Pressure reducing pad while in chair. -Pressure reducing mattress on bed. -Skin barrier cream/ointment to protect skin as needed. -Turn and reposition while in bed every 2 hours. R10's nurse practitioner nursing home visit note dated 12/13/25, included an order to discontinue all prior wound buttocks wound treatments and new order for buttocks wound treatment of zinc barrier cream mixed with collagen powder twice daily and as needed for incontinence. The visit note did not include wound status and/or characteristics. R10's Skin Assessments dated 12/12/25, 12/19/25, 12/26/25, 1/2/26, and 1/9/26, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Skin Assessments dated 1/17/26 indicated no change to the size of the stage two pressure ulcer on the left buttock since 11/14/25. The assessment identified the stage 2 ulcer with measurements 2.0 cm x 1.0 cm., marked as improving. No other wound characteristics were included. R10's nurse practitioner (NP) note dated 1/21/26, identified R10 was seen for wound care management. R10 had a stage 3 pressure ulcer on left buttocks near the crease. Original size was 1.7 cm x 1.0 cm x 0.2 cm with current size of 2.0 cm x 3.6 cm x 0.1 cm. Edges distinct and epithelization. Wound bed with granulation and epithelization. Minimal serous (clear and watery) drainage. Tender and not odor present. Periwound with blanchable erythema. Identified current physician orders as wash per facility protocol, pat dry, apply foam dressing, change every 3rd day and as needed for rolling/soiling. Do not apply barrier cream with collagen powder to wound. -Zinc powder with collagen powder on other perianal wounds twice daily and as needed. -Do not scrub or wash barrier cream off when soiled. -Encourage repositioning every 2 hours while in bed to offload pressure. -During the day encourage R10 to lay down for at least 60 minutes at a time to offload pressure at least twice daily. If R10 does not want to lay down at least verify R10 is clean and dry and reposition in wheelchair. In review of R10's record between 11/14/25 when the stage 2 pressure ulcer was first identified through 1/21/26 when the NP identified the ulcer had deteriorated to a stage 3 , there was no indication the existing pressure relieving interventions were evaluated for effectiveness, and no new interventions were added . Additionally, R10's record did not include	20900		

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20900	Continued from page 23 a comprehensive assessment that identified R10's skin tolerance to pressure over time; it could not be ascertained how every two-hour positioning schedule first initiated on 9/24/25 (prior to ulcer development) was appropriate or effective. R10's physician order dated 1/22/26 directed for other sacral wounds apply zinc barrier cream mixed with collagen powder twice daily and as needed. "Do not apply where dressing for left buttocks wound cut". The transcribed order did not direct the application of the foam dressing changed every 3rd day. Review of R10's January and February 2026 TAR included the physician order that had been transcribed without the foam dressing. The TARs indicated R10's wound treatments were completed without using the foam dressing according to transcribed order. R10's Skin Assessment dated 1/23/26, 1/30/26, 2/6/26, 2/13/26, 2/20/26, and 2/27/26 did not identify the correct staging of the ulcer according to the nurse practitioner instead the assessment identified a healing stage 2 pressure ulcer to left buttocks measuring 2.0 cm x 1.0 cm indicating the wound remained the same size since first identified on 11/14/25. The assessment did not include any wound characteristics. In review of R10's record between 11/15/25 through 2/27/26 revealed R10's record did not include weekly comprehensive skin assessments and even though the TAR directed wound monitoring for any wounds for changes was completed (denoted by check marked boxes) and treatments were completed according to orders (denoted by check marked boxes) that were transcribed, there was no documentation of wound status and characteristics. R10's nursing home nurse practitioner note dated 2/28/26, identified R10's pressure injury stage 3 to left sacral region had resolved. During an interview on 3/2/26 at 12:18 p.m., R10 was in her room seated in her wheelchair. R10 explained she had a "sore" on her bottom but believed it was getting better. R10 stated when she was in bed, staff did come in at night to reposition her every 2 hours. R10 explained in the morning once she got up for the day, she spent most of her time in her electric wheelchair that could lean back "this helps me get off my bottom". R10 then used her controls on her wheelchair to lean back in her chair 45-degree angle which although redistributed the amount of weight from R10's bottom did not completely offload all of her weight from her bottom. R10 stated sometimes she could not tell if her bottom was getting sore because of her MS, "this may be why I got a sore on my bottom." R10 further stated staff did not come into her room to give her direction to reposition while in her chair, so she tried to remember to do it herself, but "sometimes forgets". R10's wheelchair had a ROHO cushion on it with the words "FRONT" on the front of the cushion. R10	20900		

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20900	Continued from page 24 stated that the aides had put this wording on the front of the cushion, because staff kept putting the cushion in her chair backwards. R10 stated if her cushion was backwards her bottom worse if not placed correctly. R10 was unaware how long ago the wording was added to the cushion. During an interview on 3/2/26 at 12:34 p.m., trained medication aide (TMA)-C stated R10's wheelchair allowed her to reposition herself in her chair if she felt the need to get off her bottom. TMA-C was unaware R10 was supposed to be repositioned every hour in her chair and was not sure if staff were supposed to remind R10 to reposition in her chair. During an interview on 3/2/26 at 12:38 p.m., nursing assistant (NA)-D stated was she responsible for caring for R10 today but was unaware R10 was supposed to lay down in bed for one hour and was unaware R10 needed to be repositioned every hour while in her wheelchair. NA-D stated once R10 was in her recliner she would notify staff when she wanted to be checked and changed. During the day R10 spent the majority of the time in her wheelchair and did not like to lay in her bed. R10's electric wheelchair reclined to different positions which R10 would do that herself, however, staff did not track how often R10 repositioned. NA-D was not able to articulate how R10's chair was able to take pressure off her bottom. NA-D further explained R10's the chair reclining would not be considered "offloading" her bottom; R10 would have to be completely off her bottom. During an interview on 3/2/26 at 12:40 p.m., licensed practical nurse (LPN)-C stated R10's left buttocks wound had not had an order for a foam dressing since 1/21/26, the wound has been treated with mixing collagen powder with zinc oxide twice a day even though the physician order directed the use of one. LPN-C explained this order should have been clarified with the nurse practitioner before it had been removed off of the orders. LPN-C indicated even though the treatment order was not followed, R10's wound had been healing. During an interview on 3/2/26 at 3:07 p.m., registered nurse manager (RN-NM) stated R10's pressure ulcer on her left sacral region was facility acquired and developed on 11/14/25. RN-NM reviewed R10's skin assessments from 1/22/26 through 2/27/26 and believed the assessments were inaccurate with measurements since R10's left buttocks pressure ulcer as healed on 2/28/26. RN-NM also identified R10's weekly skin assessments were not considered comprehensive. RN-NM was unaware the pressure ulcer was first identified as a stage 2 pressure ulcer and then had deteriorated to a stage 3 pressure ulcer. RN-NM stated R10 was supposed to be turned and repositioned every 2 hours in bed and every hour in her wheelchair "R10 has MS and is not able to feel when she may be having buttocks	20900		

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20900	Continued from page 25 pain" RN-NM was now aware that direct care staff were relying on R10 to reposition herself when she was in her wheelchair. RN-NM explained R10's every 2-hour turning and repositioning was given as an order by the nurse practitioner; RN-NM was not aware if the frequency was appropriate or effective. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated she was unaware R10's pressure ulcer on her left buttocks had deteriorated to a stage 3 pressure ulcer on 1/21/26. R10's wound staging should have been identified as stage 3 since 1/21/26 remained at stage 3 until the wound had been determined it had healed. On 3/2/26 at 1:05 p.m. and 3:45 p.m., attempted to contact R10's nurse practitioner responsible for her pressure ulcer care, however, did not get a return phone call. R4 R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated 12/23/25, identified R4 was cognitively intact, had no behaviors, no rejection of care, no range of motion limitations on upper or lower extremities, need substantial/maximum assistance for rolling side to side, was dependent for sit to stand, dependent for chair to bed, at risk for pressure ulcers, no unhealed pressure ulcers, had MASD, treatments of pressure reducing device in chair and bed, application of nonsurgical dressings and ointments. R4's ADL focus care plan revised on 12/27/25, identified R4 had a self-care deficit related to weakness, history of stroke, cancer of the pancreas and liver, and diabetes with neuropathy (a type of nerve damage that happens with diabetes). Goal to improve current function in ADLs. Interventions as follows: -Bed mobility extensive assistance of two staff to turn and reposition in bed. -Partial assistance of two staff with a sit to stand mechanical lift for transfers. R4's skin integrity focus care plan revised on 1/7/26, identified R4 had a potential/actual impairment to skin integrity with old scarring from previous pressure injuries on bilateral buttocks related to incontinence of urine and stool. Goal to free from skin related infection. Interventions as follows: Wound/Skin treatment as ordered (date 12/18/25). -Use a draw sheet of lifting device to move resident (date 12/18/25). -lotion dry skin areas as necessary (date 12/18/25). -Skin barrier cream/ointment to protect skin as needed (date 12/18/25). -Pressure relieving/reducing pad while in chair (date 12/18/25). -Pressure reducing mattress on bed (date 12/27/25). -Assist with offload every two hours in bed and chair (date 12/27/25). R4's nursing home visit nurse practitioner note dated 12/22/25, identified R4 had been admitted with a	20900		

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20900	Continued from page 26 wound to left buttocks (the note did not identify type of wound nor wound characteristics including measurements). The note included orders to cleanse wound with wound cleanser, pat dry, apply small amount of Iodosorb (antimicrobial gel directly to open wound area, cover with dry gauze and secure with foam dressing. R4's progress note dated 1/19/26, identified a situation, background, assessment, response (SBAR) was sent to physician that wound to buttocks in now open and bleeding. Buttocks has keloid skin to the right and skin tags that had an open area and the left had an open area as well. Asked for new treatment for the wound. The note did not include any further description of the wound. R4's physician orders dated 1/20/26, identified order to buttocks wounds as follows: -Wash per facility protocol and pat dry. Cover with silicone bordered foam dressing and change every 3rd day and as needed for rolling or getting soiled. (Start date 1/20/26 through 2/9/26). -Buttocks wounds peel dressing back to assess wound once daily. Start date 1/20/26 through 2/9/26) R4's Skin Assessment dated 2/3/26, identified R4 had non-blanchable redness to the right buttocks near the gluteal cleft and bilateral buttocks had red/purple discoloration that was blanchable. Left buttocks had 1.2 cm x 1.2 cm open area. Corresponding progress note dated 2/3/26 included R4's bottom was starting to look macerated with non-blanchable redness noted to the right buttocks near the intragluteal cleft. R4's nursing home nurse practitioner note dated 2/6/26, identified a stage 2 pressure injury to the left medial buttocks and incontinence associated dermatitis. Pressure ulcer had three small open wounds on the left buttocks close together measuring 1.0 cm x 1.0 cm x 0.1 cm. More proximal (center of the body) on the left buttocks measures 1.5 cm x 1.0 cm x 0.1 cm. Edges attached and open. Wound bed denuded (loss of top layer of skin), fragile, and non-blanchable erythema. Minimal bloody drainage and tender with no odor. Periwound fragile and pink. Ulceration had gotten larger. Treatment orders as follows: -Wash buttocks wound per facility protocol, pat dry, cover with silicone bordered foam dressing, peel back daily to assess daily and change every 3rd day and as needed rolling/soiling. R4's Skin Assessment dated 2/6/26, identified R4 had thick scar tissue with 1.2 cm x 1.2 cm open wound to the left buttocks, with red/purple discoloration that is blanchable. Treatment orders in place. The assessment did not include further description of the wound nor address the second wound as identified by the NP. R4's Skin Assessment dated 2/13/26, identified R4's left buttocks had thick scar tissue with 1.2 cm x 1.2 cm open wound to left	20900		

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20900	Continued from page 27 buttocks. Bilateral buttocks had red/purple discoloration that was blanchable. Identified as healing. No further description was included. Review of R4's record from 2/14/26 through 2/25/26 did not include a comprehensive wound assessment had been completed of R4's buttock wounds. During an observation and interview on 2/25/26 at 10:10 a.m., R4 was lying in a bed on top of a deflated air mattress that had been unplugged. There was no other barrier between the metal bedframe and the plastic material of the mattress. NA-C and NA-D entered R4's room, NA-D stated R4's air mattress was totally "deflated and must have been unplugged by accident." NA-D was unsure how long R4's mattress had been unplugged or when the last time R4 had been turned and repositioned in bed. NA-D then plugged R4's air mattress back in the outlet. R4 was assisted by NAs to stand up using a sit-to-stand lift exposing the back of R4's incontinent brief which had a silicone foam dressing stuck on the right side. NA-D stated, "How did that get there?, it is supposed to be on his wound on his bottom." As NA-D removed R4's brief an open wound was observed on R4's right buttock that was approximately 2.0 cm x 1.0 cm in size. The wound had uneven edges and was macerated (white, soft, wrinkled skin due to excessive moisture). Base of the wound was pink and R4 denied pain in the area. R4's bilateral buttocks had thick skin that was light brown (hyperpigmentation) in color with no redness or purple noted. NA-D stated R4 was going to get a shower, then the nurse would check his skin and apply a new dressing. During an interview on 2/25/26 at 10:45a.m., RN-B stated she had been told earlier that R4 had a new open area on his right buttocks and needed to put a dressing on it. RN-B explained that by R4's air mattress being deflated for an unknown time this could cause injury to R4's bottom. RN-B indicated she was not responsible for completing the comprehensive wound assessments, the nurse managers completed them. R4's Skin Assessment dated 2/26/26, identified R4 had moisture associated skin damage (MASD) to left buttocks measuring 2.5 cm x 1.0 cm; stage 2 pressure injury to right buttocks measuring 2.5 cm x 1 cm; and bilateral deep tissue injury measuring 9.0 cm x 8.0 cm. Wound identified as worsening. Assessment did not identify any further details of the pressure injury. R9 R9's face sheet dated 3/1/26, identified diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's significant Change MDS dated 1/26/26, identified R9 had intact cognition, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was	20900		

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20900	Continued from page 28 dependent for chair/bed to chair transfers, was at risk for developing pressure ulcers, had one stage 2 pressure ulcer, R9's Braden Scale for Predicting Pressure Sore Risk dated 1/26/26, identified R9 was moderate risk for developing pressure ulcers due to being slightly limited in sensory perception, being occasionally moist, chairfast, completely immobile, problem with friction/shear. R9's ADL focus care plan revised on 5/21/25, identified R9 had a self-care deficit related to weakness, respiratory failure, and kidney failure. Goal to maintain current level of function. Interventions as follows: -Transfers: dependent with assist of two staff using a full body mechanical lift. -Bed mobility: dependent with one to two staff for repositioning and turning in bed. R9's pressure ulcer focus care plan dated 5/21/25, identified R9 had potential for pressure ulcer development related to history of ulcers and immobility. Goal to have intact skin. Interventions as follows: -Assist of two staff to turn and reposition every 2 hours in bed and chair, more often as needed or requested. Pressure relieving mattress on bed (dated 2/16/19). -Pressure reducing device on wheelchair (dated 12/16/19). -Lay resident down between meals and prop to either side using pillows to fully offload buttocks. If refused report to the nurse (dated 1/28/26). -May leave lift sling under due to discomfort with removing and replacing. Skin checks increased to twice per week (dated 1/28/26). R9's Skin Assessment dated 1/13/26, identified left buttocks wound with an open area that measured 0.5 cm x 0.5 cm, no drainage, center is red in color. Mepilex dressing applied. The assessment did not include any other characteristics. R9 nurse practitioner nursing home visit note dated 1/13/26, identified R9 had been having severe pain in buttocks for past 3 weeks with pain relieved by lying flat in bed. Stage 2 pressure ulcer on left buttocks identified. Treatment orders to wash per facility protocol, pat dry, cover with silicone bordered foam dressing, change every 3rd day and as needed and frequent repositioning and offloading pressure. In review of R9's record despite the order for frequent repositioning/offloading there was no indication of a comprehensive assessment to determine the frequency of repositioning nor evident the care plan was revised with a change from every two hour positioning which was identified as an intervention on 2/16/19. Review of R9's Skin Assessments dated 2/3/26 through 2/21/26 indicated the measurements of the left buttock wound remained the same. The assessments each identified a wound with an open area that measured "approximately" 1.3 cm x 0.75 cm.	20900		

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20900	Continued from page 29 Area cleansed and patted dry, skin prep and bordered foam dressing applied on each assessment. The assessments did not include any other wound description or characteristics. R9's Skin Assessment dated 2/24/26, indicated the wound to the left buttock had deteriorated. The assessment included the wound had an open area, wound bed appears superficial, pink/red in color, no drainage, measures 2.5 cm x 3.0 cm. New bordered foam dressing applied. The assessment did not include any other wound description or characteristics. R9's Weekly Wound/Complex Wound Observation Tool dated 2/27/26, identified R9 had a stage 2 pressure ulcer on left buttocks that measured 0.8 cm x 1.6 cm with no depth. Wound was acquired while in the facility. - During an interview on 3/2/26 at 12:40 p.m., LPN-C stated R9 was turned and repositioned every 2 hours while in bed and the chair, which he allows. R9's wound on his left buttock has been improving with turning and repositioning and treatments. LPN-C further explained that the skin assessments that were done on bath days were not comprehensive assessments because many of them were completed by LPN's and not an RN. LPN-C was unsure which registered nurses was responsible for the assessments and staging of a wound. During an interview on 2/26/26 at 2:06 p.m., Minimum Date Set Coordinator Registered Nurse (MDS-RN) stated she had noticed "a while ago" that residents with pressure ulcers had not had a weekly comprehensive wound assessment of their wounds completed and had informed her concern to upper management, but continued to notice that the comprehensive assessment have not been completed. During an interview on 3/2/26 at 3:07p.m., RN-NM stated she had not been performing any comprehensive assessments of residents with pressure ulcers and was not aware that a registered nurse needed to complete the comprehensive assessment each week. RN-NM explained she had not been given directions to be responsible for completing the wound assessment for the residents with pressure ulcers; the only direction she received to ensure the weekly bath skin assessments by the floor nurses. RN-NM further explained she had not received any wound assessment education and without having this education she would not "feel comfortable" performing the assessments also RN-NM believed that any staff could assess the wounds and was not aware a registered nurse would need to complete the assessment to ensure it was correct and appropriate treatments and pressure reducing measures were in place. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated registered nurse manger (RN-NM) had been assigned the responsibility of ensuring the weekly pressure ulcer assessments were being completed. DON explained when she started reviewing	20900		

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20900	Continued from page 30 wound documentation she realized the weekly skin bath audits were completed however, not the comprehensive wound assessments. Any resident with pressure ulcers should have had a weekly comprehensive registered nurse (RN) assessment of the wounds to ensure the appropriate treatment and pressure prevention measures were in place. The comprehensive assessment should have included: type of wound, location, date acquired, staging, length, width, depth, description of wound base, edges, and drainage. DON reviewed R10, R4, R9's record and identified no RN weekly comprehensive wound assessments had been completed since identification of the pressure ulcers and they "should have been completed." DON explained the purpose of the comprehensive assessment being done by an RN would be to ensure the pressure ulcers are assessed for healing and/or deterioration and to ensure proper pressure relieving measures/treatments are in place. Review of the facility's Prevention and Treatment of Skin Breakdown Policy undated, identified it was the policy of the facility to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Procedure as follows: Skin Ulcer Data Collection & Assessment sheets are used for pressure, stasis, arterial and neuropathic ulcers. Data is provided by the floor nurse or nurse manager on resident's bath day. RN assesses the information and writes a progress note detailing the wound appearance, treatment, and healing progress. Treatment orders to be followed as MD prescribes, measurements of wounds only need to be documented weekly. If wound worsens consecutively for 2-3 weeks a note to the MD is sent with request for new orders. Prevention of Pressure Ulcers A. Braden Scale* and Comprehensive Risk Data Collection form (which includes a skin audit) will be done: • Upon admission • Weekly for the first 4 weeks post admission, • Quarterly, and • With a change in status (i.e., pressure ulcer development, change in mobility, continence status, Change in cognition, nutrition, etc.). Please see Policy and Procedure for Braden Scale & Comprehensive Risk Data Collection in the Forms and Care Plans section for instructions. A. Turning and Repositioning Observation (capturing turning & repositioning). Pressure is the primary cause of pressure ulcers. An effective turning and repositioning schedule can help reduce the risk of developing a pressure ulcer. Everyone's tissue tolerance (the ability of the skin and its supporting structures to endure the effects of pressure without breakdown), is	20900		

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20900	Continued from page 31 different. Therefore, it is important to individualize each resident's turning and repositioning schedule. For those residents that are immobile, or need assistance with mobility, complete a Turning and Repositioning (Tissue Tolerance) Observation form: • Upon admission, • Re-admission, • With a change of condition (including the development of a pressure ulcer or change in mobility status), • Annually and, • In both the lying and sitting position. B. Monitoring of Skin Integrity • Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. • Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications.	21545	corrected	04/02/2026

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21545	Continued from page 32 B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility /failed to /ensure that 1 of 1 resident (R1) was free of a significant medication error by not /observing /the rights of medication administration. This caused actual harm for R1 when she was administered another resident’s /medications /became /unresponsive and /had to be hospitalized for hypotension and acute kidney injury. In addition, based on observation and interview the facility failed to ensure appropriate correction measures after R1’s medication errors to decrease the risk or reduce the risk of significant medication errors and could have prevented or reduced the risk additional medication errors that were not significant for 2 of 2 residents (R12, R5) observed during medication pass. Findings include: R1’s face sheet dated 2/27/26, /identified /diagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners). R1’s admission Minimum Data Set (MDS) dated 2/13/26, /identified /R1 had	21545		

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21545	Continued from page 33 moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant. R1's physician orders /identified /the following: -Midodrine (a drug used to treat orthostatic hypotension /and increase blood pressure) 5 mg three times per day related to orthostatic hypotension. Do not take if systolic blood pressure (top blood pressure) if greater than 150. -Vitamin D (supplement) tablet /50 /micrograms (mcg) one time per day. -Pantoprazole (drug to reduce stomach acid) /40 /milligram (mg) one time per day. -Apixaban (blood thinner) 5 mg by mouth one time per day. -Rosuvastatin (drug to treat high cholesterol) 20 mg one time per day. -Calcium carbonate (supplement) 1500 mg 2 tablets two times per day. R1's Medication Error incident report dated 2/13/26, /identified /R1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for evaluation. /The investigation notes identified the medications that R1 received included: Atorvastatin 40 mg (milligrams-lipid/cholesterol management), Clopidogrel 75 mg, (antiplatelet-increases risk for bleeding) Duloxetine 30mg, (antidepressant) Empagliflozin 10 mg (diabetic management), Famotidine, (reduces stomach acid) Lamotrigine 100mg (anticonvulsant/mood stabilizer), Losartan 25 mg (treats hypertension) Metoprolol 25 mg (treats hypertension/heart rate control) Potassium 20 mEq,(treats low potassium) and Torsemide 20 mg /(diuretic and hypertension) R1's progress note dated 2/13/26 at /7:35 a.m., /identified /nurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident's /medication /by mistake. Nurse called the on-call physician and informed the medications /R1 received and was instructed to /monitor /resident for any adverse reactions to any of the medications. R1's progress note dated 2/13/26 at 9:20 a.m., /identified /nurse was called into R1's room by nursing assistant because R1 became unresponsive. R1 was lying with eyes closed, did not respond to verbal commands. "Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace." Blood pressure 137/82 (normal blood pressure is under 120/80) and heart rate 92 (normal heart rate is 60-100), respirations 18 (normal respirations 12-18), oxygen saturations 97% (normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED). R1's emergency department (ED) note dated 2/13/26, /identified /R1 was seen in the ED after becoming unresponsive after	21545		

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21545	Continued from page 34 receiving another resident's medications at 7:35 a.m. A list of medications that was administered was as follows: Atorvastatin 40 mg, Clopidogrel, 75 mg, Duloxetine 30mg, Empagliflozin 10 mg, Famotidine, Lamotrigine 100mg, Losartan 25 mg, Metoprolol 25 mg, Potassium 20 milliequivalent (mEq), and Torsemide 20 mg. R1 had become somnolent (sleepy) and not acting herself at the nursing home so was sent to ED for evaluation. /Blood pressure on admission to the ED was 133/59. Blood urea nitrogen (lab value to evaluate kidney function) "slightly up trending." /R1's blood pressure at 10:58 a.m., decreased to 97/48 millimeters of mercury (mm/Hg) and one liter of fluid bolus /initiated. R1 was admitted /for /monitoring /for hypotension and resolution of a mild acute kidney injury. R1's hospital progress note dated 2/14/26, /identified /diagnoses of accidental drug ingestion, hypotension secondary to accidental drug ingestion, blurry vision secondary to accidental drug ingestion, and orthostatic hypotension. On 2/14/26 /she endorsed blurry vision which the note /identified /this could be a side effect of the medication of the low blood pressures. R1's hospital discharge summary dated 2/17/26, identified R1 had been hospitalized 2/13/26 through 2/17/26 after being inadvertently administered another patient's medications at a skilled nursing facility. On presentation R1 was somnolent (sleepy and or drowsy) and did not follow commands, had a single episode of hypotension that responded to intravenous (IV) fluids. Laboratory evaluation revealed an acute kidney injury with a creatinine elevated to 1.36 milligram/deciliter (mg/dl). The medication error of receiving medications not prescribed to R1 and was admitted for close monitoring of hemodynamics and renal (kidney) function. R1 experienced symptomatic orthostatic hypotension with dizziness and blurry vision on standing, /required /ongoing conservative management including compression wraps, abdominal binder, hydration, and gradual titration of midodrine to 10 mg three times per day. R1's acute kidney injury resolved with IV fluids and avoidance of nephrotoxic agents (medication that cause kidney damage). R1 was discharged on 2/17/26 to another skilled nursing facility. During an interview on 2/24/26 at 4:06 p.m., trained medication aide (TMA)-A /stated /she was agency staff and had worked a handful of times at the facility. She had not worked with R1 before and had not seen R1 before. During the day shift on 2/13/26, TMA-A prepared R2's medications, verified R2's picture in the electronic health record (EHR), /identified /R2's room number, however, TMA-A entered R1's room instead. TMA-A did not verify the room number prior to entering R1's and /then entered R1's room to administer the	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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

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21545	Continued from page 35 medications. TMA-A then /proceeded /to administer R2's medications to R1. /When TMA-A /attempted /to give R1 an inhaler R1 stated, "I don't take an inhaler.", TMA-A realized her error. /TMA-A left R1's room and /verified on the EHR that she had mistakenly given R2's medications /to R1. TMA-A immediately /called the nurse to inform them of error and took R1's vital signs. TMA-A /stated /she did not follow the rights of medication administration to ensure the correct resident received the correct /medications. TMA-A further /stated /she had not had /orientation /on medication pass or any /previous /education on rights of medication administration /at this facility. During an interview on 2/24/26 at 1:44 p.m., licensed /practical nurse (LPN)-B /stated /she had been notified by TMA-A on 2/13/26 around 7:30 a.m., that R1 received R2's medications. LPN-B /stated /she /immediately /came to the unit to check on R1. R1's vitals were /stable; however, she was concerned about getting the wrong /medications. LPN-B /stated, "I don't even know how TMA-A made that kind of error and told her she should have verified she was giving the medications to the right resident." LPN-B further /stated /if TMA-A had performed her rights of medication administration she would have not made the mistake. During an interview on 2/25/26 at 1:04 p.m., medical director (MD) /stated /she considered R1's medication error that occurred on 2/13/26 to be considered a significant error. MD further stated R1 becoming hypotensive and developing an acute kidney injury was /likely caused /by getting medication that were not prescribed to her. Staff should have followed the rights of medication administration /for all residents /to /ensure safe medication administration /utilized. During an interview on 2/20/26 at 4:04 p.m., director of nursing (DON) /stated /she had been informed 2/13/26 at 8:00 a.m., that R1had inadvertently received R2's medications at 7:30 /a.m. DON /stated /she instructed the nurse to /monitor /and ensure the physician had been informed of R1's medication error. The nurse had informed DON that R1 was doing "fine" and she was being /monitored. DON then /arrived /at the facility around 8:45 a.m. /to /9:00 a.m. Shortly after the DON arrival she /was /notified /that R1 had become unresponsive. DON then /immediately /went to R1's room where R1 was found lying in bed and not responding /to verbal commands. R1's vitals /had been /taken and were stable, but continued to not respond, so /DON /sent /R1 to the ED for evaluation. DON stated R1's medication error occurred because the rights of medication administration had not been followed /by TMA-A and the wrong medication was given to the wrong resident. R1 was admitted /for observation, but did not return to the facility, so she did not know the outcome. /TMA-A had told DON that	21545		

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21545	Continued from page 36 as /she prepared R2's medications, believed she had /entered R2's room, however after administering R1 all of R2's pills, she had tried to /offer R1 an /inhaler, /when R1 stated /that /was not her medication. TMA-A /then /told her she realized she had given medications /to the incorrect resident and notified the nurse immediately. DON then sent TMA-A home and /stated /she had provided /verbal education to the staff that was /working on /the rights of medication administration, however, did not have any documentation of her education provided. DON /stated /the facility then began competency testing of the staff that administered medication to ensure that the rights of medication /were /being followed. During an interview on 2/24/26 at 12:56 p.m., TMA-D /stated /he /had recently had education and competency testing provided by one of the LPNs to ensure he know how to pass medications correctly. He did not recall exactly what kind of education /he had received. TMA-D was able to name five of the seven rights of /medication /administration, however, /was /not /aware of "right rationale or right /documentation" /being /part of the rights of medication administration. During an interview on 2/24/26 at 2:11 p.m., TMA-B /stated /she had recently received education on the rights of /medication /administration and had competency /done by the administrator. /TMA-B /stated /she did not recall exactly what the education was /about, /but /believed it was /just about how /the process of /doing the medication pass correctly and making sure we are doing /all of /the steps correctly. During an interview on 2/24/26 at 4:52 p.m., administrator /stated /she was not a licensed nurse, however, had /completed some of the /staff medication administration competencies /and education even thought she had not had /any formal /training /on medication administration or the rights of medication administration /to /be able to /determine /if staff were deemed /competent /doing a medication pass. During an interview on 2/24/26 at 4:52 p.m., /DON /stated /she had not performed any of /the /medication administration /training or /competencies /done with staff. She had /a few /staff /deemed /competent by a registered nurse, but /most of /the staff /had been completed by the administrator /(who was not a licensed nurse /nor had /any /education on medication administration) /or by /a /licensed practical nurse. DON /stated /the competencies/education that had been completed by /administrator, /or the /LPNs /would not be considered valid, /due to those staff not having the capability to /determine /competency of the staff or provide education. DON /stated /the /staff that /were /responsible for medication /administration /should have had	21545		

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21545	Continued from page 37 their /competencies /and/or education /done /by a registered nurse /only. R12's face sheet dated 2/27/26, /identified /diagnoses of heart failure and /gastroesophageal reflux disease. During an observation /and interview /on 2/25/26 at 7:52 a.m., registered nurse (RN)-B prepared medications for R12 by verbalizing and comparing the order to the medication package label. RN-B walked to R12 and verified R12's identity with name and date of birth and compared image of R12 in the electronic health record (EHR). RN-B then informed R12 what each medication was and then handed R12 a liquid oral antifungal /in a small cup, instructed R12 to swish the medication in his mouth then spit the medication out. RN-B then realized the medication was supposed to be a swish and swallow versus a swish and spit. RN-B /stated /she must have misread the order as a /swish and spit verses a swish and swallow and this would be a medication error. /RN-B /stated /she had /a "kind of audit" done recently by the /administrator /while she passed /medication /to ensure she was doing them correctly. RN-B did not recall getting any recent education on the rights of medication administration. R5's face sheet dated 2/27/26, /identified /diagnoses of heart failure, /Parkinson's /disease, and dementia. R5's quarterly MDS dated 12/3/25, /identified /R5 /had intact cognition, /no behaviors, took an antianxiety medication, and received hospice services. R5's physician orders dated 1/30/26, /identified /an order for Lorazepam (anti-anxiety) give 1 mg three times per day for anxiety. R5's Medication Error Incident /Report dated 2/21/26, /identified /R5 received an extra dose of Lorazepam at 4:45 p.m. During an interview on 2/26/26 at 2:28 p.m., TMA-C /stated /she had /a recent medication pass audit and competency test given by the /administrator /along with education on the rights of medication administration. However, despite the education she had made a medication error on 2/21/26 when she gave R5 a extra dose of Lorazepam on 2/21/25. /TMA-C explained she had thought R5 had orders for an as needed dose but did not verify R5's physician orders prior to administering the dose of Lorazepam on 2/21/26 at 4:45 p.m. TMA-A /stated /she should have ensured the rights of medication administration were done prior to administering R5's medication, and if /she /had /followed the rights of medication administration she would not have /made R5's medication /error. TMA-C recited the rights of medication and identified R5's medication error was the result of not administering the right dose of medication. /TMA-C /indicated she has continued to pass medications even though she had not received any	21545		

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21545	Continued from page 38 re-education since the error was made on 2/21/26. TMA-C explained the DON would be providing education on a later date. During an interview on 2/25/26 at 2:59 p.m., DON stated R5's medication error on 2/21/26 was due to TMA-C not performing the rights of medication not being followed and therefore an error happened that had the potential of being a significant error in certain residents. DON /stated /she had not given TMA-C formal re-education on the rights of medication administration but was planning /on doing /it "soon". Review of the facility's Administering Medications Policy dated 2/26, /identified /the following: -The individual administering medications verifies the resident's identity before giving the resident /his/her /medications. Methods of /identifying /the residents include: a. checking identification /band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right /time /and right method (route) of administration before giving the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days, then weekly, then monthly to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		

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F0000	INITIAL COMMENTS On 4/8/26 through 4/10/26, an onsite revisit was conducted to follow up on deficiencies related to a standard complaint survey exited on 3/2/26. The facility was found to be NOT in compliance with the requirements of §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in a recited deficiency at F842 and an additional citation at F580. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/30/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F0580	F580 Notification to Provider 1. Upon identification of the concern, the provider for R3 was immediately notified of the change in condition and the delay in notification. A nursing progress note was entered into the medical record to reflect R3 condition, the provider notification and any orders received. The medical record was reviewed to ensure it accurately reflects R3 current status. 2. Identification of others The Director of Nursing conducted a review of residents to identify if others may have experienced a significant change in condition to ensure provider notifications were completed. No additional residents were identified with concerns related to delayed provider notification. 3. Systemic corrections	05/07/2026

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 reverse for further 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.

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

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F0580 SS = D	Continued from page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify a physician for a change of condition for 1 of 3 residents (R3) who had a syncopal episode. Findings include: R3's diagnoses list dated 4/10/26 included pneumonia, acute respiratory failure, chronic heart failure, chronic kidney disease, atrial fibrillation, and syncope. R3's admission Minimum Data Set (MDS) dated 4/1/26 indicated no cognitive deficits.	F0580	Continued from page 1 On 4/23/2026, licensed nursing staff were re-educated on the facility's Change of Condition and Provider Notification policy. Education included: When to notify the provider (including significant changes in condition) Timeliness expectations for notification a. Process Change Implemented: A standardized expectation was implemented requiring: provider notification for all significant changes in condition 4. Monitoring The Director of Nursing or designee will audit 3 chart audits weekly x4 weeks, then 3 charts monthly x3 months. Audits will include: Evidence of provider notification Any identified concerns will result in immediate correction, staff re-education, and follow-up audit to ensure compliance. 5. Quality Assurance Results will be reported to the QAPI committee for review, trending, and additional interventions as needed. 6. Compliance Date: 05/07/2026	05/07/2026

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F0580 SS = D	Continued from page 2 R3's health status note dated 4/4/26 at 9:09 a.m., trained medication assistant (TMA)-A reported on 4/3/26 R3 had "passed out" for a few seconds during a transfer. A nurse was notified and evaluated R3. In review of R3's record there was no indication the physician was notified. R3's care plan dated 3/26/26 indicated on 4/6/26 R3's transfer status was changed to assist of two for all transfers due to possible vagal response. During an interview on 4/10/2026 at 11:30 a.m., TMA-A stated on 4/3/26 she placed a gait belt on R3 then assisted him to a standing position. Upon rising, R3 started to lean forward, then "went limp" so TMA-A lowered him back into his recliner. After he sat down, his eyes opened, and he said "hi". TMA-A immediately called for assistance over the walkie talkie. Licensed practical nurse (LPN)-A, LPN-B and registered nurse manager (RN-NM) responded to the call for assistance. During an interview on 4/10/2026 at 11:39 a.m., LPN-A stated on 4/3/26 at change of shift, TMA-A requested assistance in R3's room. LPN-A responded with LPN-B and RN-NM. R3 was alert when LPN-A entered the room. Because it was the end of her shift, LPN-A left the room with LPN-B and RN-NM caring for R3. LPN-A stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 2:52 p.m., LPN-B stated on 4/3/26 she responded to a call for assistance in R3's room. When she entered, R3 was alert and following commands. LPN-B stated she did not check vital signs, did not update the provider and did not complete a nursing note because there was a lot going on that shift. LPN-B stated a note should be written and a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:46 a.m., RN-NM stated on 4/3/26 she responded to a request for help in R3's room. When RN-NM entered R3's room, R3 was alert and LPN-B was obtaining vital signs. R3 had not had an episode like that before at the facility. RN-NM stated there was no nurse's note about the event on 4/3/26 and no indication in the chart the provider had been notified. RN-NM stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:05 a.m., director of nursing stated the provider should have	F0580		05/07/2026

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F0580 SS = D	Continued from page 3 been notified about the event the day it occurred because it was a significant change from R3's baseline. During an interview on 4/10/2026 at 9:51 a.m. medical doctor (MD) stated she learned of R3's dizziness episode on 4/8/26 through asking routine questions during rounds at the facility. MD would have wanted to be notified right away following the episode. The Change of Condition policy dated 2/2026 instructed to notify the physician in the event of a status change.	F0580		05/07/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F0842	F842 R1 medical record was reviewed by the Director of Nursing to ensure documentation accurately reflects the resident's current wound status. Erroneous documentation was corrected per facility policy. A follow-up nursing note was entered to support current condition. R3 medical record was updated to reflect an accurate chart note that R3 has not seen on wound rounds due to being out of the building. The Director of Nursing updated the medical record to reflect R3's current condition. Provider was notified via SBAR regarding the documentation discrepancy and R3 status. Nurse Manager was re-educated on proper documentation protocol and expectations for accurate wound round documentation. The Director of Nursing completed follow-up nursing progress notes for all current wound care residents to ensure documentation accurately reflects wound status and care provided. Identification of others On 4/10/2026, the Director of Nursing conducted a house-wide audit of all residents with current or recent skin integrity concerns. This included review of wound care rounds documentation, progress notes, and treatment records. On 4/10/26 any discrepancies were corrected at the time of review. No additional residents were identified with	05/07/2026

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F0842 SS = D	Continued from page 4 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain a complete and accurate medical record for 2 of 3 residents (R1, R3) reviewed for pressure ulcers.	F0842	Continued from page 4 inaccurate or missing documentation. Systemic Corrections On 4/23/2026, licensed nursing staff were re-educated on accurate, timely, and complete documentation requirements. Nurse manager was re-educated on 4/14/2026 regarding correct documentation for wound rounds, Comprehensive wound assessment, Provider notification, Progress note. Education for all nursing department staff included: skin prevention policy, documentation policy, implementing orders regarding skin integrity, wound round schedule, who to contact with skin issues, Monitoring To ensure compliance, the Director of Nursing or Designee will conduct 3 chart audits weekly x 4 weeks then 3 charts/month x 3 months. Results will be reported to QAPI for review and any further recommendations. Compliance date: 5/7/2026	05/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/10/2026

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

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F0842 SS = D	Continued from page 5 R1's diagnoses list dated 4/7/26 included hypertensive heart disease, Parkinson's disease, polyneuropathy and dementia. R1's quarterly Minimum Data Set (MDS) dated 3/4/26 indicated R1 had moderate cognitive impairment. R1 was at risk for pressure injuries and did not have a pressure injury or moisture related skin damage (MASD). R1's health status note dated 4/7/26 at 2:00 p.m., indicated registered nurse manager (RN-NM) did weekly rounds with wound care provider. See comprehensive wound assessment uploaded to resident's chart. Orders updated to reflect weekly visit. In review of R1's electronic medical record (EMR) the corresponding wound care provider note dated 4/8/26 (for visit on 4/7/26) which included treatment orders and wound measurements was uploaded into the record two days later on 4/9/26 at 10:22 a.m. R3's diagnoses list dated 4/10/26 included pneumonia, acute respiratory failure, chronic heart failure, chronic kidney disease, atrial fibrillation, and syncope. R3's admission minimum data set (MDS) dated 4/1/26 indicated no cognitive deficits. R3's order administration note dated 4/7/26 at 10:22 a.m. indicated R3 was out of the facility with family. R3's order administration note dated 4/7/26 at 6:43 p.m. indicated R3 was out of the facility with family. R3's skin/wound note dated 4/7/26 at 1:59 p.m. RN-NM did weekly rounds with the wound care provider. See comprehensive wound assessment uploaded to resident's chart. Orders updated to reflect weekly visit. In review of R3's record, there was no indication orders were updated on 4/7/26 and the record did not include any uploaded wound visit notes dated 4/7/26. During an interview on 4/9/2026 at 12:56 p.m., health unit coordinator (HUC) stated all faxes sent to the facility were received into a fax folder on the computer. HUC, RN-NM and director of nursing (DON) had access to the folder. When a fax came into the folder, HUC received a notification. Then she would print the fax, enter any provider orders into the EMR, then give the printed order to RN-NM. HUC stated R1's wound care notes and orders were received on 4/8/26 but that day had been busy, so the information was not entered into the chart until	F0842		05/07/2026

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F0842 SS = D	Continued from page 6 4/9/26. HUC had not received a wound care note or orders for R3. During an interview on 4/9/2026 at 1:12 p.m. RN-NM stated the facility utilized a specialized wound care company to do wound assessments. A facility RN would round with the wound care NP as the NP completed the assessment of each resident's wound including the measurement of the wound and received verbal updates of the wound and order changes. RN-NM did not need to document the assessment in the residents' EMR because that would be double charting. The wound care NP would then fax the assessment and wound care orders to the facility following the on-site visit. After the wound care NP's note and orders were received, the HUC would enter the order into the EMR. Then RN-NM would double-check the order for accuracy and sign and date the order. If an order needed to be clarified, RN-NM would contact the wound care NP. RN-NM further stated on 4/7/26 RN-NM rounded with the wound care NP and did not document an assessment of the wound or new orders in the R1's EMR. RN-NM also stated R3 had been out of the facility on 4/7/26 and had not been seen by the wound care NP nor had he received new wound care orders. RN-NM stated she should not have documented that R3 had been seen by the wound provider. R3's health status note dated 4/4/26 at 9:09 a.m., indicated trained medication assistant (TMA)-A reported on 4/3/26 R3 had "passed out" for a few seconds during a transfer. A nurse was notified and evaluated R3. Writer noticed the information was not documented in the chart. The note did not include any other information pertaining to the change in condition. In review of R3's record there was no indication of documented assessment/evaluation by a nurse following the syncopal episode. During an interview on 4/10/2026 at 11:30 a.m., TMA-A stated on 4/3/26 she placed a gait belt on R3 then assisted him to a standing position. Upon rising, R3 started to lean forward, then "went limp" so TMA-A lowered him back into his recliner. After he sat down, his eyes opened, and he said "hi". TMA-A immediately called for assistance over the walkie talkie. LPN-A, LPN-B and registered nurse manager (RN-NM) responded to the call for assistance. During an interview on 4/10/2026 at 11:39 a.m., licensed practical nurse (LPN)-A stated on 4/3/26 at change of shift, TMA-A requested assistance in	F0842		05/07/2026

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F0842 SS = D	Continued from page 7 R3's room. LPN-A responded with LPN-B and RN-NM. R3 was alert when LPN-A entered the room. Because it was the end of her shift, LPN-A left the room with LPN-B and RN-NM caring for R3. LPN-A stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 2:52 p.m., LPN-B stated on 4/3/26 she responded to a call for assistance in R3's room. When she entered, R3 was alert and following commands. LPN-B stated she did not check vital signs, did not update the provider and did not complete a nursing note because there was a lot going on that shift. LPN-B stated a note should be written and a provider should be updated any time a resident had a change in condition During an interview on 4/10/2026 at 11:46 a.m., RN-NM stated on 4/3/26 she responded to a request for help in R3's room. R3 was alert and LPN-B was obtaining vital signs when RN-NM arrived in the room. R3 had not had an episode like that before at the facility. RN-NM stated there was no nurse's note about the event on 4/3/26 and no indication in the chart the provider had been notified. RN-NM stated a provider should be updated any time a resident had a change in condition. During an interview on 4/9/2026 at 5:18 p.m., director of nursing stated documentation in a resident's chart should be completed as soon as possible after an assessment is completed or orders are received. RN-NM should not have written a note in R1's about the wound care assessment and orders until RN-NM had verified the information had been entered into the chart. RN-NM should not have written a note stating R3 had seen the wound care NP when he had not. LPN-B should have written a note about R3's "passing out" on 4/3/26. During an interview on 4/10/2026 at 9:51 a.m., medical doctor stated nurses should document an assessment as soon as possible after the assessment was completed. Provider orders should be entered into the EMR as soon as the facility receives the order. The Charting and Documentation policy dated 3/2026 instructed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be	F0842		05/07/2026

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F0842 SS = D	Continued from page 8 objective (not opinionated or speculative), complete, and accurate.	F0842		05/07/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/8/26 through 4/10/26, an onsite revisit was conducted to follow up on deficiencies issued related to a complaint survey exited on 3/2/26 by the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Nursing Home Licensure. The following licensing order issued will remain IN EFFECT, and a penalty assessment issued: 20625. A new licensing order was issued at 20265.	20000		04/30/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/10/2026**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	20000		04/30/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times	20265	Corrected	05/07/2026

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20265	Continued from page 2 for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify a physician for a change of condition for 1 of 3 residents (R3) who had a syncopal episode. Findings include: R3’s diagnoses list dated 4/10/26 included pneumonia, acute respiratory failure, chronic heart failure, chronic kidney disease, atrial fibrillation, and syncope. R3’s admission Minimum Data Set (MDS) dated 4/1/26 indicated no cognitive deficits. R3’s health status note dated 4/4/26 at 9:09 a.m., trained medication assistant (TMA)-A reported on 4/3/26 R3 had “passed out” for a few seconds during a transfer. A nurse was notified and evaluated R3. In review of R3’s record there was no indication the physician was notified. R3’s care plan dated 3/26/26 indicated on 4/6/26 R3’s transfer status was changed to assist of two for all transfers due to possible vagal response.	20265		05/07/2026

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20265	Continued from page 3 During an interview on 4/10/2026 at 11:30 a.m., TMA-A stated on 4/3/26 she placed a gait belt on R3 then assisted him to a standing position. Upon rising, R3 started to lean forward, then “went limp” so TMA-A lowered him back into his recliner. After he sat down, his eyes opened, and he said “hi”. TMA-A immediately called for assistance over the walkie talkie. Licensed practical nurse (LPN)-A, LPN-B and registered nurse manager (RN-NM) responded to the call for assistance. During an interview on 4/10/2026 at 11:39 a.m., LPN-A stated on 4/3/26 at change of shift, TMA-A requested assistance in R3’s room. LPN-A responded with LPN-B and RN-NM. R3 was alert when LPN-A entered the room. Because it was the end of her shift, LPN-A left the room with LPN-B and RN-NM caring for R3. LPN-A stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 2:52 p.m., LPN-B stated on 4/3/26 she responded to a call for assistance in R3’s room. When she entered, R3 was alert and following commands. LPN-B stated she did not check vital signs, did not update the provider and did not complete a nursing note because there was a lot going on that shift. LPN-B stated a note should be written and a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:46 a.m., RN-NM stated on 4/3/26 she responded to a request for help in R3’s room. When RN-NM entered R3’s room, R3 was alert and LPN-B was obtaining vital signs. R3 had not had an episode like that before at the facility. RN-NM stated there was no nurse’s note about the event on 4/3/26 and no indication in the chart the provider had been notified. RN-NM stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:05 a.m., director of nursing stated the provider should have been notified about the event the day it occurred because it was a significant change from R3’s baseline. During an interview on 4/10/2026 at 9:51 a.m. medical doctor (MD) stated she learned of R3’s dizziness episode on 4/8/26 through asking routine questions during rounds at the facility. MD would have wanted to be notified right away following the episode.	20265		05/07/2026

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20265	Continued from page 4 The Change of Condition policy dated 2/2026 instructed to notify the physician in the event of a status change. SUGGESTED METHOD OF CORRECTION: The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		05/07/2026
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods;	20625	Corrected	05/07/2026

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20625	Continued from page 5 G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain a complete and accurate medical record for 2 of 3 residents (R1, R3) reviewed for pressure ulcers. Findings include R1’s diagnoses list dated 4/7/26 included hypertensive heart disease, Parkinson’s disease, polyneuropathy and dementia. R1’s quarterly Minimum Data Set (MDS) dated 3/4/26 indicated R1 had moderate cognitive impairment. R1 was at risk for pressure injuries and did not have a pressure injury or moisture related skin damage (MASD). R1’s health status note dated 4/7/26 at 2:00	20625		05/07/2026

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20625	Continued from page 6 p.m., indicated registered nurse manager (RN-NM) did weekly rounds with wound care provider. See comprehensive wound assessment uploaded to resident's chart. Orders updated to reflect weekly visit. In review of R1's electronic medical record (EMR) the corresponding wound care provider note dated 4/8/26 (for visit on 4/7/26) which included treatment orders and wound measurements was uploaded into the record two days later on 4/9/26 at 10:22 a.m. R3's diagnoses list dated 4/10/26 included pneumonia, acute respiratory failure, chronic heart failure, chronic kidney disease, atrial fibrillation, and syncope. R3's admission minimum data set (MDS) dated 4/1/26 indicated no cognitive deficits. R3's order administration note dated 4/7/26 at 10:22 a.m. indicated R3 was out of the facility with family. R3's order administration note dated 4/7/26 at 6:43 p.m. indicated R3 was out of the facility with family. R3's skin/wound note dated 4/7/26 at 1:59 p.m. RN-NM did weekly rounds with the wound care provider. See comprehensive wound assessment uploaded to resident's chart. Orders updated to reflect weekly visit. In review of R3's record, there was no indication orders were updated on 4/7/26 and the record did not include any uploaded wound visit notes dated 4/7/26. During an interview on 4/9/2026 at 12:56 p.m., health unit coordinator (HUC) stated all faxes sent to the facility were received into a fax folder on the computer. HUC, RN-NM and director of nursing (DON) had access to the folder. When a fax came into the folder, HUC received a notification. Then she would print the fax, enter any provider orders into the EMR, then give the printed order to RN-NM. HUC stated R1's wound care notes and orders were received on 4/8/26 but that day had been busy, so the information was not entered into the chart until 4/9/26. HUC had not received a wound care note or orders for R3. During an interview on 4/9/2026 at 1:12 p.m. RN-NM stated the facility utilized a specialized wound care company to do wound assessments. A facility RN would round with the wound care NP as the NP completed the assessment of each resident's wound including the measurement of the wound and received verbal updates of the wound and order changes. RN-NM did not need to document the	20625		05/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/10/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20625	Continued from page 7 assessment in the residents' EMR because that would be double charting. The wound care NP would then fax the assessment and wound care orders to the facility following the on-site visit. After the wound care NP's note and orders were received, the HUC would enter the order into the EMR. Then RN-NM would double-check the order for accuracy and sign and date the order. If an order needed to be clarified, RN-NM would contact the wound care NP. RN-NM further stated on 4/7/26 RN-NM rounded with the wound care NP and did not document an assessment of the wound or new orders in the R1's EMR. RN-NM also stated R3 had been out of the facility on 4/7/26 and had not been seen by the wound care NP nor had he received new wound care orders. RN-NM stated she should not have documented that R3 had been seen by the wound provider. R3's health status note dated 4/4/26 at 9:09 a.m., indicated trained medication assistant (TMA)-A reported on 4/3/26 R3 had "passed out" for a few seconds during a transfer. A nurse was notified and evaluated R3. Writer noticed the information was not documented in the chart. The note did not include any other information pertaining to the change in condition. In review of R3's record there was no indication of documented assessment/evaluation by a nurse following the syncopal episode. During an interview on 4/10/2026 at 11:30 a.m., TMA-A stated on 4/3/26 she placed a gait belt on R3 then assisted him to a standing position. Upon rising, R3 started to lean forward, then "went limp" so TMA-A lowered him back into his recliner. After he sat down, his eyes opened, and he said "hi". TMA-A immediately called for assistance over the walkie talkie. LPN-A, LPN-B and registered nurse manager (RN-NM) responded to the call for assistance. During an interview on 4/10/2026 at 11:39 a.m., licensed practical nurse (LPN)-A stated on 4/3/26 at change of shift, TMA-A requested assistance in R3's room. LPN-A responded with LPN-B and RN-NM. R3 was alert when LPN-A entered the room. Because it was the end of her shift, LPN-A left the room with LPN-B and RN-NM caring for R3. LPN-A stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 2:52 p.m., LPN-B stated on 4/3/26 she responded to a call for assistance in R3's room. When she entered, R3 was alert and following commands.	20625		05/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/10/2026**

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20625	Continued from page 8 LPN-B stated she did not check vital signs, did not update the provider and did not complete a nursing note because there was a lot going on that shift. LPN-B stated a note should be written and a provider should be updated any time a resident had a change in condition During an interview on 4/10/2026 at 11:46 a.m., RN-NM stated on 4/3/26 she responded to a request for help in R3's room. R3 was alert and LPN-B was obtaining vital signs when RN-NM arrived in the room. R3 had not had an episode like that before at the facility. RN-NM stated there was no nurse's note about the event on 4/3/26 and no indication in the chart the provider had been notified. RN-NM stated a provider should be updated any time a resident had a change in condition. During an interview on 4/9/2026 at 5:18 p.m., director of nursing stated documentation in a resident's chart should be completed as soon as possible after an assessment is completed or orders are received. RN-NM should not have written a note in R1's about the wound care assessment and orders until RN-NM had verified the information had been entered into the chart. RN-NM should not have written a note stating R3 had seen the wound care NP when he had not. LPN-B should have written a note about R3's "passing out" on 4/3/26. During an interview on 4/10/2026 at 9:51 a.m., medical doctor stated nurses should document an assessment as soon as possible after the assessment was completed. Provider orders should be entered into the EMR as soon as the facility receives the order. The Charting and Documentation policy dated 3/2026 instructed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of	20625		05/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20625	Continued from page 9 those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		05/07/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 5, 2026

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

Re: CCN: 245369
Cycle Start Date: March 2, 2026

Dear Administrator:

On April 10, 2026, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2026 with orders received by you electronically on March 18, 2026.

State licensing orders issued pursuant to the last survey completed on March 2, 2026 found not corrected at the time of this April 10, 2026 revisit and subject to penalty assessment are as follows:

20625 - MN Rule 4658.0450 Subp. 1 A-P -- Clinical Record Contents; In General $300.00

The details of the violations noted at the time of this revisit completed on April 10, 2026 are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115

Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Health Program Manager
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on April 10, 2026 additional violations were cited as follows:

20265 - MN Rule 4658.0085 -- Notification of Change in Resident Health Status

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 5, 2026

Administrator
ST MARKS LIVING
400 15TH AVENUE SOUTHWEST
AUSTIN, MN 55912

RE: CCN: 245369
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 18, 2026, we notified you a remedy was imposed. On May 14, 2026, 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 May 7, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 2, 2026, be discontinued as of May 7, 2026. (42 CFR 488.417 (b))

In our letter of March 18, 2026, 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 March 2, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

June 5, 2026

Administrator
ST. MARK'S LIVING
400 15TH AVENUE SW
Austin, MN 55912

RE: 1F170E-H3

Dear Administrator:

On June 5, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $300 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on May 14, 2026, and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $300. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $1252.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $1552.80 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
Financial Management
St. Paul MN 55164-0975

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

cc: Shellae Dietrich, Program Assurance Supervisor
Kami Fiske-Downing, Licensing and Certification Program
HRD Deposit Team