DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2022

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

RE: CCN: 245369
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 26, 2022, we notified you a remedy was imposed. On September 7, 2022 the Minnesota Departments of Health and Public Safety 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 September 2, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 10, 2022 be discontinued as of September 2, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 1, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 20, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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
August 26, 2022

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

RE: CCN: 245369
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 26, 2022, we informed you of imposed enforcement remedies.

On August 12, 2022, the Minnesota Department(s) of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

F0678 -- S/S: J -- 483.24(a)(3) -- Cardio-Pulmonary Resuscitation (cpr)

REMOVAL OF IMMEDIATE JEOPARDY

On August 12, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 August 10, 2022, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 10, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 10, 2022.

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 July 26, 2022, 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 July 20, 2022.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 July 20, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 December 16, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 08/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 678} SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system to identity a resident's Physician Orders for Life Sustaining Treatment (POLST) to initiate cardio-pulmonary resuscitation (CPR) or do not resuscitate (DNR) wishes were accurate for 4 of 4 residents (R1, R2, R3, and R4) whose POLST's were inaccurate or not documented per the facility policy/procedure. This resulted in an immediate jeopardy (IJ) and placed four residents (R1, R2, R3, R4) at risk for not having their wishes followed. The immediate jeopardy began on 8/11/22, when the facility failed to identify inconsistencies and/or inaccuracies that included missing POLST, wrong code status, and more than one POLST in the paper chart. The administrator and director of nursing (DON) were informed of the IJ on 8/11/22, at 4:38 p.m. The IJ was removed on 8/12/22, at 2:00 p.m. but non-compliance remained at the lower scope and severity of a E, no actual harm with potential for more than minimal harm. Findings include: The facility policy, Emergency Procedure -	{F 678}	How will Corrective action be accomplished for those residents found to have been affected by the deficient practice? Facility reviewed code status policy and procedure. R1 has a signed POLST and matches in all locations (soft chart, EHR - orders/resident profile, care sheet, and if POLST was scanned into PCC MISC file) Facility updated R2's records for POLST to match in all locations (soft chart, EHR - orders/resident profile, care sheet, and if POLST was scanned into PCC MISC file). Facility updated R'3s soft chart so it only included the most current POLST. R4's POLST was added to all locations (soft chart, EHR - orders/resident profile, care sheet, and if POLST was scanned into PCC MISC file). How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility has done multiple audits on all charts to verify POLST is up to date and matching in all locations (soft chart, EHR -	8/12/22

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

Electronically Signed | 08/26/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	R 08/12/2022

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{F 678}	Continued From page 1 Cardiopulmonary Resuscitation, updated 8/5/22, directed the initiation of CPR should not be initiated until the resident's POLST has been reviewed. The facility procedure for CPR directed a paper copy of the most current POLST will be stored at the nurse's station and staff were directed to go to the paper chart to identify POLST status. R1 R1's admission Minimum Data Set (MDS) identified R1 was admitted to the facility on 8/9/22, and did not have cognitive impairment. R1's record identified R1's paper chart did not include a POLST as per the facility's policy. R2 R2's Face Sheet printed 8/12/22, indicated R2 was admitted to the facility on 2/12/21. R2's quarterly MDS dated 7/28/22, indicated R2 did not have cognitive impairment. R2's record identified R2's electronic health record (EHR) included a copy of R2's POLST dated 4/9/21 directed DNR. However, the POLST in the paper chart (location the policy instructed to verify) dated 2019, directed staff to perform CPR. During an interview on 8/11/22, at 2:52 p.m. R2 stated they wished to have a code status of DNR. R3 R3's Face Sheet printed on 8/12/22, indicated R3 was readmitted to the facility on 7/5/22. R3's admission MDS 7/11/22 , identified an admission date of 7/5/22, indicated R3's cognitive	{F 678}	orders/resident profile, care sheet, and if POLST was scanned into PCC MISC file) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility trained DON and Nurse Managers on what to do if a new POLST or a change is required. The family wishes (responsible party) will be met on new POLSTs until a physician has signed. The Polst will be placed in the residents folder with residents or the responsible party's signature until a fully executed document is available to take its place. DON and Nurse Managers were trained on 8/12/22 on what to look for during the audit process to ensure accuracy and availability in the event of a medical emergency. Training included: During a CPR chart review audit: -ensure all POLSTs are signed by resident and physician -ensure POLST is matching in all locations - soft (paper) chart - EHR *Under Code Status on Resident Profile *Order in Orders Tab -Care Sheets -ensure POLST is electronically stored in the Misc Tab in PCC and in the soft (paper) chart -ensure only the current POLST is in the soft (paper) chart. With any change in POLST, REPLACE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 678}	Continued From page 2 pattern was not assessed. R3's record review included two POLST's in R3's soft chart. The first POLST located in the paper chart dated 2018, directed DNR. A second POLST and was found dated 7/18/22, that directed to perform CPR. The paper chart did not identify which was accurate or intended for reference. R4 R4's Face Sheet printed on 8/12/22, indicated R4 was admitted to the facility on 3/2/20. R4's quarterly MDS dated 7/25/22, indicated R4's did not have cognitive impairment. R4's record identified R4's paper chart did not include a POLST. R4's EHR Miscellaneous Tab included a POLST that was signed on 8/22/19, directing to have CPR. During an interview on 8/12/22, at 11:05 a.m. licensed practical nurse (LPN)-A stated all staff were educated to go to the paper chart to obtain residents POLST status. Upon reviewing R1's paper chart, with LPN-A, she stated R1 did not have a POLST in his paper chart and every paper chart should have the current POLST. During an interview on 8/11/22, at 12:43 p.m. nursing assistant (NA)-A stated they were reeducated to go to the POLST located in the paper chart. Non-CPR trained staff would go to the paper chart and find the POLST, and then radio the DNR/CPR status to staff who are CRP trained. During an interview on 8/11/22, at 12:48 p.m.	{F 678}	previous POLST in soft (paper) chart. Only the most recent POLST should be in the chart. The entire resident audit needs to be completed by one nursing team member in order to ensure all of the information is consistent in each of the required places. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Facility will audit all charts once per week for 4 weeks. Facility will audit all new admissions within two business days for the next 10 admissions	

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{F 678}	Continued From page 3 RN-A stated current POLSTs were in the paper chart at the nurse's station. In the event of an emergency, staff who were not CPR certified would verify code status in the paper chart while CPR trained staff were directed to stay with the resident and prepare for CPR if directed. During an interview on 8/11/22, at 3:00 p.m. LPN-A stated nurse managers kept the paper chart up to date so only one POLST that was current should be in the paper chart at the nurse's station. Because not all staff had access to computers in resident rooms, having POLST in a centralized location was the fastest way to obtain the code status. During an interview on 8/11/22, at 3:05 p.m. DON stated there is only one POLST per paper chart. If there is an update, the HUC will print a new POLST and remove the outdated POLST. DON stated she and nurse managers completed the POLST audits and were unaware there were any inaccuracies. The immediate jeopardy that began on 8/11/22, was removed on 8/12/19, at 2:00 p.m. when the facility completed a re-audit of all residents. All resident POLST's was reviewed using the most current signed POLST and comparing the document to PCC physician order and Medication Administration Record.	{F 678}		

Electronically delivered

July 26, 2022

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

RE: CCN: 245369
Cycle Start Date: June 16, 2022

Dear Administrator:

On July 1, 2022, we informed you that we may impose enforcement remedies.

On July 20, 2022, the Minnesota Department of Health completed a survey and it has been determined that 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On July 20, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 10, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 10, 2022 They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 10, 2022.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 July 20, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an E tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 December 16, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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
July 26, 2022

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

Re: Event ID: X00Y11

Dear Administrator:

The above facility survey was completed on July 20, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245369	A. BUILDING _____ B. WING _____	C 07/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/18/22, through 7/20/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F678 began when licensed practical nurse (LPN)-A failed to follow Provider Orders for Life Sustaining Treatment (POLST) and did not initiate cardiopulmonary resuscitation (CPR) as per resident (R)7's wishes. R7 subsequently died. The administrator and director of nursing (DON) were notified of the IJ on 7/19/22, at 4:05 p.m. The IJ was removed on 7/20/22, at 4:20 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 7/20/22. The following complaint was found to be SUBSTANTIATED: H53693352C (MN00085178), with a deficiency cited at F678. The following complaint was found to be UNSUBSTANTIATED: H53693207C (MN00084893). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		8/9/22

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

Electronically Signed | 08/01/2022

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

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F 678	Continued From page 1 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST), did not initiate cardiopulmonary resuscitation (CPR) as per the residents wishes for CPR for 1 of 3 resident (R)7 resident reviewed for CPR status. R7 was found without a pulse or respirations and staff did not initiate CPR and R7 expired. This resulted in an Immediate Jeopardy (IJ) for R7. The IJ began on 7/16/22, at 4:40 a.m. when licensed practical nurse (LPN)-A failed to follow the POLST and did not initiate CPR as per R7's wishes. The administrator and director of nursing (DON) were notified of the IJ on 7/19/22, at 4:05 p.m. The facility implemented corrective action and the IJ was removed on 7/20/22, at 4:20 p.m. but non-compliance remained at scope and severity of D, isolated which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R7's five-day Minimum Data Set (MDS) dated 7/16/22, identified R7 was admitted to the facility on 7/15/22, was not cognitively impaired, had clear speech, was able to understand others and make herself understood by others. In addition, R7 did not have signs/symptoms of delirium.	F 678	How will Corrective action be accomplished for those residents found to have been affected by the deficient practice? Facility updated policies and procedures in place. Removed the phrasing b. there are obvious signs of irreversible death (e.g., rigor mortis). Adjusted policy to locate POLST before initiating CPR. Staff will be trained and competency tested to locate code status to determine if CPR should be initiated. Staff will be trained to start CPR for any unsigned POLSTs per CPR Policy. Nurses will be trained and competency tested on the updated policies and proper procedures prior to the start of their shift starting on 8/5/22 all staff will be completed with training by 8/9/2022. All nursing staff have been trained and competency tested on where to locate POLSTs. How will the facility identify other residents having the potential to be affected by the same deficient practice? Facility assessed all POLSTs (soft chart, EHR - orders/resident profile, care sheet, and if POLST was scanned into PCC	

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F 678	Continued From page 2 R7's POLST dated 7/15/22, directed in the event of cardiopulmonary arrest, staff would attempt resuscitation and begin CPR. R7's POLST was signed by certified nurse practitioner on 7/15/22. During an interview on 7/19/22, at 1:58 p.m. LPN-A stated nursing assistant (NA)-A assisted R7 to the commode around midnight and was on every two-hour resident safety checks. NA-A observed R7 sleeping at 2:00 a.m. and LPN-A explained at approximately 4:30 a.m. NA-A called on the walkie-talkie and requested help in R7's room. Upon arrival to R7's room NA-A indicated R7 was not breathing. LPN-A stated she assessed for a pulse and respirations and finding none, she left NA-A with R7 and went to get her stethoscope. Upon return, LPN-A listened for an apical pulse and stated R7 had passed away. LPN-A stated she did not know the code status for R7, so she went to the nurse's station a second time to access R7's PointClickCare (PCC) electronic medical record. When LPN-A discovered R7 was full code, she elected to not start CPR because R7 had already passed away. LPN-A obtained a (resident) Death responsibility check list and attempted to call the director of nursing (DON) and the unit nurse manager. She was unable to contact either one of the nursing leaders, so she called 911 and requested a police officer and county coroner but not an ambulance because R7 had already passed away. LPN-A reiterated she did not perform CPR and "it was her fault." During an interview on 7/19/22, at 12:45 p.m. NA-A stated he was making his every two-hour resident safety check and while conducting his observation of R7 at approximately 4:30 a.m. it appeared she was not breathing. Upon touching	F 678	MISC file) and identified all residents had code status identified and consistent in the charts. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur? Facility updated policies and procedures in place. Removed the phrasing b. there are obvious signs of irreversible death (e.g., rigor mortis). Adjusted policy to locate POLST before initiating CPR. Staff will be trained and competency tested to locate code status to determine if CPR should be initiated, if POLST is unsigned, staff will initiate CPR. Nurses will be trained and competency tested on the updated policies and proper procedures prior to the start of their shift starting on 8/5/22 all staff will be completed with training by 8/9/2022. All nursing staff have been trained and competency tested on where to locate POLSTs. All new nursing staff & supplemental nursing service agency workers will be trained and competency tested during orientation. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Facility will Audit POLSTs in all four locations once per week and within 24-48 hours of a new admission for four weeks. Audits will be reviewed at QAPI for further recommendations.	

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F 678	Continued From page 3	F 678		

R7 she felt warm and immediately called the nurse (LPN-A) for assistance. When LPN-A arrived in R7's room, she attempted to find a pulse and was unsuccessful and observed R7 was not breathing. NA-A stated he asked LPN-A if R7 was DNR or full code and LPN-A stated she did not know. LPN-A quickly left R7's room returned with her stethoscope and listened to R7's chest. LPN-A indicated R7 had passed away. NA-A asked if they should start CPR and LPN-A indicated it was too late.

During an interview on 7/19/22, 4:30 p.m. registered nurse (RN)-B stated during end of shift hand-off, LPN-A stated R7 passed away earlier that morning. LPN-A further stated to RN-B R7 was full code but she did not start CPR because she "was not going to put R7 through that. She had already passed away."

During an interview on 7/19/22, at 1:05 p.m. director of nursing (DON) stated she was notified of R7's passing at approximately 6:00 a.m. on 7/16/22. DON indicated LPN-A had reported to her she had not known R7's code status until she checked PCC, and did not initiate CPR or request an ambulance because R7 was already dead.

During a follow-up interview on 7/20/22, at 11:33 a.m. DON stated during her first interview with LPN-A, LPN-A stated it was too late to start CPR because R7's eyes were fixed and dilated and her lips were blue. LPN-A further stated that R7 was still warm and did not have signs irreversible death. She knew she should have started CPR and takes full responsibility for her lack of action. DON explained her expectation that staff would follow the POLST and start CPR if that is the resident's wishes. LPN-A should have started

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F 678	Continued From page 4 CPR. The facility policy, Emergency Procedure - Cardiopulmonary Resuscitation, last revised 04/2016, referencing the AHA Guidelines for CPR and Emergency Cardiovascular Care, directed if a resident is found unresponsive and not breathing normally, a staff member certified in CPR/BLS shall initiate CPR. The IJ that began on 7/16/22, was removed on 7/20/22, at 4:20 p.m. after the facility-initiated training for all staff on their responsibilities, per American Heart Association guidelines, of how to respond to a resident in suspected cardiac and/or respiratory arrest. Additionally, training included training on the updated Emergency Procedure - Cardiopulmonary Resuscitation policy which directed staff to initiate CPR immediately when there was an unwitnessed arrest or when code status was unknown until EMS arrives or when code status of DNR could be confirmed. Facility staff training that were on duty included CNA's, trained medication assistant, LPN, and RN's, were interviewed to ensure all staff were knowledgeable of their responsibilities and changes to the CPR policy.	F 678		

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	00394	A. BUILDING: _____ B. WING _____	C 07/20/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/18/22 through 7/20/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H53693352C (MN00085178), however, no licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H53693207C (MN00084893). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		