STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor non-pressure related impairments in skin integrity for 3 of 3 (R1, R2, R3) residents reviewed for injuries. Addtionally the facility failed to ensure appropriate interventions were in place to reduce bruising for 1 of 1 resident (R1) at risk for bruising due to taking an anticoagulant (medication that prevents blood clots from forming) Findings include R1 R1's face sheet dated 3/19/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow). R1's focus care plan dated 8/7/24, identified R1 is at risk for bruising/bleeding/adverse effects with anticoagulant therapy with a goal of skin will remain intact and minimal bruising. Interventions included: monitor, document, and report bruising. R1's order summary dated 3/19/25, identified R1 was on an anticoagulant for atrial fibrillation. R1's skin assessment on 2/24/25 at 3:02 a.m., identified R1 had a new bruise on right inner upper arm measuring 33 centimeters (cm) x 20 cm. The assessment did not include characteristics of the bruise. R1's progress note dated 2/24/25 at 4:32 a.m., identified R1 was observed thrashing around under cover and a large 33 centimeters (cm) x 20 cm, bruise noted to right upper arm and resident stated it happened from hitting his side rails while boosting self-up in bed. Noted resident is on anticoagulant and pad protectors needed for side rails. Will pass along in shift report regarding bruise and bed rail concern. R1's skin assessment dated [DATE], identified a bruise on right upper arm measuring 33 cm x 20 cm and was caused by bumping into bed rail. R1 denied pain and skin condition poor and is on anticoagulation medications. Licensed nurse analysis identified recommendation for protection pads on side rails. R1's record did not identify protection pads placed on bed rails or monitoring of the bruise. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's outside medical record dated 2/24/25, identified physician notified that R1 was observed thrashing around under his covers and obtained a large bruise to upper right inner arm. Measurement of 33 cm x 20 cm. R1 denies pain to the area. No noticeable warmth and skin in poor condition. In review of R1's record between 2/24/25 and 3/19/25, there was no indication the bruising was continuously monitored or assessed to identify worsening or improvement. During an observation and interview on 3/18/25 at 3:56 p.m., R1 was seated in his wheelchair in his room. R1's bed had a positioning bar on the left and right side, however, did not have any protective covers on them. Observed two long brown clothlike sleeves with openings on the hand area sitting on nightstand folded up. Registered nurse (RN)-A observed R1's left forearm and noted a bruise measuring 14 1/2 cm x 10 cm and was described as irregular in shape, purple in color and raised to touch, without pain, and no warmth. RN-A also noted 1 cm x 1.5 cm purple, circular, raised area in the left arm near the antecubital area (triangular depression on the inner surface of the elbow joint). No bruise noted on the upper right inner arm. R1 stated the bruise on his right arm was from bumping his bars in his bed but is gone now. RN-A stated R1 bumps his arms on the rails when turning side to side and has fragile skin. RN-A has not seen any protection pads on R1's bed to protect his arms and was unsure whether he used protective sleeves on his arms. RN-A explained since R1 was on a blood thinner she would notify the physician of the bruising and new hematoma by sending a situation, background, assessment, and recommendation (SBAR). Review of R1's record on 3/19/25, did not identify physician notification of the hematoma or bruising on left forearm observed on 3/18/25. During an interview on 3/19/25 at 11:10 a.m., licensed practical nurse (LPN)-A stated for any new skin issues like bruising or hematoma a skin assessment should be done, the physician should be notified, and an order to monitor the hematoma/bruise only if the physician orders the monitoring. During an interview on 3/19/25 at 2:20 p.m., director of nursing (DON) stated she was aware of R1 having frequent bruising on his arms from bumping his arms on the bars on his bed. DON stated after the bruise observed on 2/24/25 no protective pads had been placed on the bars, however they did get protective sleeves for staff to place on R1's arms at night but the sleeves for his arms were not in the care plan or monitoring in place. R2 R2's face sheet indicated R2 had diagnoses that included chronic kidney disease stage 4 (loss of kidney function that can cause easy bruising and delay wound healing). R2's care plan focus dated 2/27/25, noted R2 had a potential impairment to skin integrity. Interventions included: - Lotion on dry skin areas as necessary (dated 1/25/24) - Skin barrier creme/ointment to protect skin as needed (dated 1/25/24) - Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (dated 1/25/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Wound/skin treatments as ordered (dated 2/1/24) - Resident will utilize pressure-relieving/reducing pad while in chair (dated 3/4/25) Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., noted it was not part of the medical record. R2 had an unwitnessed fall on 3/14/25 at 1:15 a.m. in her bathroom and had pain to the lower-left back and red/purple color observed in two areas measuring: 7.5 x 12 & 9 x 8. With no other skin issues observed. The injuries section included Injury type: bruise (flat), injury location: rear left iliac crest [upper part of hip bones]. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Appearance: pain reported on her lower-left back. Red/purple color observed in two areas measuring 7.5 x 12 & 9 x 8, range of motion good and without discomfort, no other skin issues noted. The SBAR progress note did not include a comprehensive assessment of the two noted areas of discoloration on R2's lower back. The documented assessment was limited to size (without an identified unit of measurement or identification of which individual bruise was measured), color, general location, range of motion, and the presence of pain. R2's fall care plan focus dated 3/14/25, noted R2 had an unwitnessed fall without apparent injury on 3/14/25. The intervention was 'call, don't fall' signs placed in resident room. R2's fall care plan did not identify R2's injury of multiple bruises on her back. R2's skin care plan was not revised to identify the bruises or related goals or interventions R2's progress note dated 3/15/25 at 11:25 a.m., included Did noticed [sic] couple bruises on back from fall. Will continue to monitor. R2's progress note dated 3/17/25 at 11:31 a.m., indicated the on-call provider was contacted to provide an update about R2's decreased activities participation due to having increased pain. The on-call provider stated to continue to monitor and if bruising gets bigger as if there was [a] hematoma [closed wound where blood collects outside of blood vessels] under the skin or if pain or ROM gets worse, we will need to send resident in for evaluation. R2's task charting for nursing assistants (NA's) included a Skin Observation task. Options included: scratched, red area, discoloration, skin tear, open area, none of the above observed, resident not available, or resident refused. Charting from 3/14/25 to 3/18/25 included: - None of the above observed on: 3/14/25 at 2:34 a.m., 6:30 a.m., 10:29 p.m., and 11:30 p.m.; on 3/15/25 at 8:30 p.m.; on 3/16/25 at 3:26 a.m. and 2:53 p.m.; on 3/17/25 at 4:28 a.m., 11:06 a.m., and 10:29 p.m.; and on 3/18/25 at 1:10 a.m. - Discoloration on 3/15/25 at 7:55 a.m., with follow-up questions Is this a new skin condition? marked yes and Where is the discolored area located? marked back. - Discoloration on 3/16/25 at 6:30 a.m., with follow-up questions Is this a new skin condition? marked no and Where is the discolored area located? marked back. (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marks Living	400 15th Avenue Southwest Austin, MN 55912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress notes from 3/14/25 through 3/18/25 did not identify additional assessments or monitoring of the bruises on R2's back. During an interview on 3/18/25 at 3:05 p.m., trained medication aide (TMA)-B stated nurses are responsible for assessing a resident after a fall. TMA-B further noted nurses were responsible for ongoing monitoring after a fall and this would be located on the resident's TAR. On 3/18/25 at 3:28 p.m., R2 was resting in the recliner in her room. RN-A observed the bruises on R2's back, noting there was a little bit of bruising on her left lower back that was light green in color. RN-A measured the bruising and noted three bruises. The first measured 9.0 cm x 6.0. The second bruise, underneath the first, was 7.0 cm x 1.5 cm. The third, a line of purple bruising here under her [R2's] waistband was 9.0 cm x 2.0 cm tall. RN-A stated this was the first time she had seen the bruises and noted they would have been assessed when R2 fell as nurses are typically supposed to do a head-to-toe [assessment] after a fall. RN-A explained nurses were supposed to fill out a fall checklist/packet and risk management documentation for every fall and this is where injuries would be charted. RN-A stated, I don't think we would do [document] a skin assessment unless we saw something, we would only chart if something was noted. RN-A noted that for bruising I think we are just supposed to notify the provider and monitor it to make sure it's getting better. RN-A would know if a bruise was getting better by looking back at the skin assessment of the initial injury to see if it was getting smaller. RN-A reviewed and identified the documentation of R2's bruises in the EHR only identified two bruises and there was no documentation of a third bruise. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she would complete a skin assessment after a fall if a resident had any injuries such as a skin tear, bruise, scratch, or if they broke a bone. Skin assessments were normally completed weekly, and she would note if a resident had a healing bruise from a recent fall and take measurements. Skin injuries should be monitored until they heal but was not sure how often a bruise should be monitored, she would have to ask the DON. LPN-A would document further monitoring in a progress note. LPN-A confirmed a physician order was not needed for nurses to implement plan for monitoring. LPN-A would assess the color, if it was healing, the length and measurements, any tenderness, any surrounding redness, and the location. LPN-A stated she did not know how she could tell if a bruise was getting better or worse if there was a lack of documentation and/or comprehensive assessment of a bruise. During an interview on 3/19/24 at 2:19 p.m., DON confirmed R2's record lacked a post-fall Skin Assessment, there was only an assessment of the bruises in the risk management incident report which was not a comprehensive assessment. The DON would expect a comprehensive assessment of bruising to include measurements, color, number and location, associated swelling, abrasions, bleeding, range of motion, and pain. DON did not see a comprehensive assessment of the bruises at any point and this does not meet expectations for following professional standards of practice and facility protocol. DON would expect bruises to be monitored every shift with documentation of the size, location, color and any change in color, swelling, pain, ROM, anything new, and any changes or progress noted. DON confirmed monitoring of R2's bruises wasn't done and it was not monitored in line with expectations and standards of practice. DON would expect to see the bruises on R2's care plan along with measurements, how it was obtained, what staff need to monitor for, and any treatments. The DON confirmed the bruises were not on R2's care plan. R3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air sacs). R3's focus care plan dated 2/19/25, identified potential impairment to skin integrity. Goal to be free from any skin-related infection. Interventions included: lotion dry skin, reposition while in chair: offload at least 1 minute, skin barrier cream, use caution during transfers and bed mobility to prevent striking arms, leg, and hands against any sharp or hard surface. R3's progress note dated 3/5/25 at 6:39 a.m., identified R3 was found on the floor on her left side with her recliner tipped forward and sustained a hematoma on her left side of her forehead and a skin tear on her left forearm. R3's record did not identify a comprehensive assessment of the hematoma or skin tear. Review of R3's record between 3/4/25 to 3/19/25, did not identify any monitoring of hematoma/bruise on left forehead. R3's skin assessment dated [DATE], identified a left forehead bruise measuring 3 cm x 3 1/2 cm and skin tear on right elbow measuring 2 cm x 1 cm., and overall impression of healing, however, did not identify color of bruise or pain. R3's Skin Assessment date 3/13/25 at 11:59 a.m., identified skin dry and intact and areas healed. During an observation and interview on 3/19/25 at 10:33 a.m., R3 was in her room, seated in her recliner. R3 was observed to have a yellow color bruise on her left forehead about 3 cm in diameter. R3 denied pain from the bruise and stated she must have gotten it from a fall she had a while back. During an interview on 3/18/25 at 4:10 p.m., RN-A identified R3 had had a fall on 3/4/25 and sustained a hematoma on her left forehead and currently measuring 2.5 cm x 2 1/2 cm, flat, faint-yellow color around the edges only, and without pain. RN-A stated the faint-yellow color of the bruise shows it was healing. During an interview on 3/19/25 at 1:12 p.m., director of nursing (DON) stated R1's record did not identify communication to the physician of R1's new hematoma/bruising on left forearm or any monitoring of the area. DON further stated R3's record did not identify any monitoring of the hematoma/bruise on her left forehead and her expectation would be for the physician to be notified in a timely manner for any new skin issues and a nursing order placed in the TAR to monitor these skin issues until healed. Facility policy titled Skin Assessment Policy dated 1/25, included: It is the policy of St. [NAME] Living to conduct comprehensive skin assessments for all residents to prevent, identify, and manage skin integrity issues, including pressure injuries, wounds, infections, and other dermatologic conditions . 2. Routine Skin Assessments - Daily Observations: CNAs shall observe residents' skin during routine care (bathing dressing, repositioning) and report concerns to the charge nurse . 4. Wound Care Management. - Any new or worsening wounds shall be assessed and documented, including size, depth, color, drainage, and signs of infection. - The wound care team or physician shall be consulted for appropriate treatment plans . 5. Documentation and Reporting - All skin assessments, findings, and interventions shall be documented in the resident's electronic health record (EHR). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marks Living	400 15th Avenue Southwest Austin, MN 55912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51576

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to comprehensively assess and evaluate causal factors for a fall and develop and monitor the effectiveness of appropriate interventions to reduce the risk of falls for 3 of 3 residents (R2, R1, R3) reviewed. Additionally, the facility failed to implement identified interventions for 2 of 3 residents (R1, R3) reviewed. Findings include: R2 R2's face sheet indicated R2 admitted to the facility on [DATE] and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. R2's annual Minimum Data Set (MDS) dated [DATE], indicated R2 had no falls since the prior assessment. R2 required supervision or touching assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors. R2's Morse Fall Scale assessment dated [DATE], indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points identified R2 as a high risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an actual problem/need and when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment . [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked. Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior to the fall was blank with note self-toilets. Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes root cause has been determined and complete five why's for root cause analysis were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was not part of the medical record. An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. - Predisposing physiological factors: No boxes checked and box labeled N/A - no apparent causative factor also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device. - Other information: resident used her wheelchair from recliner to bathroom. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated [DATE], indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair, cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury and intervention of call, don't fall signs placed in room. In review of R2's fall record, although the report identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's checks, nor an assessment that identified if R2 could use the call light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had always taken herself to the bathroom, but staff had been helping her since her fall. She hadn't used the call light when I've been here until now. R2 noted she had resumed toileting herself independently a day or so ago and went by myself this afternoon. R2 stated she needed to use the bathroom and shifted in the recliner, attempting to get up. This surveyor reminded R2 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on . I've never had her call for help getting up. (continued on next page)

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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marks Living	400 15th Avenue Southwest Austin, MN 55912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help. TMA-A noted R2 fell recently and we had to tell her you have to ask us [for help]. TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still? R2 replied, moving myself mostly, but sometimes I call for help. RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought she probably kind of sneaks in there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that. NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and I guess really the only intervention is to encourage the call light . it would have been prevented if she had just had her call light on. During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and toileted independently during the day. She expressed concern that R2's memory has really been slipping. NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked how staff managed this self-transferring, NA-A stated, I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers. NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but does she follow directions, no. LPN-A noted, we don't do a follow up on it after a new fall intervention is put in place and there was no re-assessment of an intervention's efficacy. On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor that she needed to use bathroom, stated I think I can get into my [wheel]chair, and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, I go by myself. This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated I guess I've got to have help to get up she [this surveyor] says. NA-A then assisted R2 with transfer from recliner to wheelchair and wheelchair to toilet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was nowhere in the medical record that documents the packet has been reviewed and the root cause discussed and the packets are not completed consistently. During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report does not include a comprehensive causal analysis of the fall. R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 lacks safety awareness if she is transferring independently. DON confirmed the incident report's analysis of R2's fall failed to identify multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and was not accurate. The DON confirmed R2's falls care plan was not up to date or accurate. I can't really explain what the cause of her fall was and how that was determined. The DON further stated, We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment . clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness. R2 R2's face sheet indicated R2 admitted to the facility on [DATE] and had diagnoses including unspecified dementia with anxiety, generalized muscle weakness, unsteadiness on feet, and a history of falling. R2's admitting diagnosis was a left femur fracture. R2's care plan focus dated 1/25/24, identified R2 was at risk for falls related to left hip fracture. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure R2 is wearing appropriate footwear (non-skid socks or rubber-soled shoes) during transfer/ambulation/mobilizing in wheelchair, physical and occupational therapies as ordered, and follow facility fall protocol. R2's care plan focus dated 1/25/24, identified R2 had an activities of daily living (ADL's) self-care performance deficit related to unspecified dementia with anxiety. Interventions dated 6/4/24, included: R2 required assistance by one staff to move between surfaces as necessary for transfers and propelled herself in a wheelchair around the facility, and R2 required assistance by one staff for toileting and would pivot transfer with stand by assist. An additional focus dated 1/25/24, identified R2 had limited physical mobility, and a corresponding intervention noted R2 did not walk. R2's provider note dated 1/30/25, included a diagnosis of history of falling (chronic). Fall-related risk factors identified were: age greater than 80, female, disability, functional limitation or limitations in ADL's, cognitive impairments, gait impairment, balance impairments, decreased muscle strength, previous falls, depression, more than four medication or psychoactive medications, diabetes, arthritis, urinary incontinence, and pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's annual Minimum Data Set (MDS) dated [DATE], indicated R2 had no falls since the prior assessment. R2 required supervision or touching assistance with toileting hygiene, moderate assistance with toilet transfers, and used a manual wheelchair independently. R2's had moderate cognitive impairment and did not exhibit rejection of care or behaviors. R2's Morse Fall Scale assessment dated [DATE], indicated R2 had fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait (stooped but able to lift head without losing balance, steps are short and resident may shuffle), and knew the limits of her ability to ambulate safely. The total score of 50 points identified R2 as a high risk for falls. R2's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/5/25, identified R2 had an actual problem/need and when the resident was assessed, she had a hard time recalling the three words that were said to her at the beginning of the assessment . [R2] has a medical diagnosis of unspecified dementia, unspecified severity, with anxiety, which could be a reason for not remembering things when asked. Facility paper Fall Report Packet/Checklist for R2 dated 3/14/25 at 1:15 a.m., included a Floor Nurse Checklist, Management Checklist, Falls Root Cause Analysis and Witness Statement, list of fall interventions, and Incident Root Cause Analysis (Five Why's). The Falls Root Cause Analysis and Witness Statement identified R2 fell in her bathroom unwitnessed while transferring/toileting/self-transferring and described the scene of the fall and observation of the resident as in the SBAR note. R2 complained of pain and requested toileting at the time of the fall and stated she slid off the edge of the toilet while turning and sitting down. She was alert and oriented, wore nonslip footwear, and care plan was followed. Call light was in reach and turned on, door closed, television and lights off, room was cool, and the last time R2 was toileted prior to the fall was blank with note self-toilets. Suggestions for prevention of another fall included: resident educated to turn on bathroom light, too dark with night light, and a sign for reminder. Interventions put in place immediately to prevent reoccurrence included: resident education, lighting turned on, and frequent checks. The Incident Root Cause Analysis (Five Why's) page was not completed. Boxes root cause has been determined and complete five why's for root cause analysis were not checked, and nurse and manager signatures were blank. The packet was provided in paper form and was not present in R2's electronic health record (EHR). Facility Incident: Un-witnessed Fall report #1474 dated 3/14/25 at 1:15 a.m., included a note identifying it was not part of the medical record. An incident description of R2's fall and immediate actions taken were transcribed in the SBAR progress note. It further included: - Injury type: bruise (flat), injury location: rear left iliac crest (upper part of hip bones). - Level of consciousness: alert, mobility: wheelchair bound. - Mental status: oriented to person, oriented to situation, oriented to place, and oriented to time. - Predisposing environmental factors: poor lighting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Predisposing physiological factors: No boxes checked and box labeled N/A - no apparent causative factor also not checked. - Predisposing situation factors: during transfer, and during transfer without assist/assistive device. - Other information: resident used her wheelchair from recliner to bathroom. R2's SBAR (Situation, Background, Assessment, and Recommendation) progress note dated 3/14/25 at 2:28 a.m., noted R2 fell and included: - Situation: At 1:15 a.m. R2's bathroom call light was activated, a nursing assistant (NA) answered and reported to the nurse that R2 had fallen. The nurse observed R2 sitting up on her buttocks next to the toilet. - Background: R2 attempted to toilet herself, the bathroom light was off with only a night light on, gripper socks were on R2's feet, R2 stated she had already pulled her pants up and reported she tried to sit down on the toilet and slid off from the side. - Appearance: R2 was calm and denied hitting her head, neurological checks were started and within normal limits (no abnormalities noted), R2 assisted off the floor and into her wheelchair with a mechanical lift and two staff, R2 then assisted with toileting and noted to have a dry brief, no other skin issues noted, follow-up vital signs taken, and neurological checks continued. - Recommendation: Reminders given to R2 to turn on the overhead bathroom light when using the toilet or transferring, also reminded to call for assistance that night if needing to use the bathroom due to the potential for pain or stiffness that could affect transferring. R2 agreed with this and staff would continue to monitor. R2's Morse Fall Scale assessment dated [DATE], indicated R2 had not ever fallen before, had multiple diagnoses, used ambulatory aides including none/bedrest/wheelchair/nurse assist, had a weak gait, and knew the limits of her ability to ambulate safely. The total score of 25 points identified R2 as a moderate risk for falls. The assessment failed to identify R2 had a history of falls, and impaired gait (difficulty rising from chair, cannot walk unassisted). R2's care plan included a focus dated 3/14/25, of a moderate risk for falls (Morse score 25-44), 3/14/2025 - unwitnessed fall without apparent injury and intervention of call, don't fall signs placed in room. In review of R2's fall record, although the report identified the causal factor of R2 self-transferred without assistance related to toileting, R2's record did not include an assessment that determined R2's individualized toileting program, did not include a comprehensive assessment that identified the frequency of R2's checks, nor an assessment that identified if R2 could use the call light appropriately related to her impaired cognition. R2's progress notes did not identify an assessment or evaluation of the causal factors of R2's fall. In addition, progress notes did not identify how appropriate interventions to decrease the risk of additional falls were developed or monitored for effectiveness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 1:27 p.m., R2 was sitting in the recliner in her room. R2 stated she fell recently when she got up to go to the bathroom, her hand slipped while turning around to sit on the toilet and she fell on the ground and hit her lower back. She had always taken herself to the bathroom, but staff had been helping her since her fall. She hadn't used the call light when I've been here until now. R2 noted she had resumed toileting herself independently a day or so ago and went by myself this afternoon. R2 stated she needed to use the bathroom and shifted in the recliner, attempting to get up. This surveyor reminded R2 to use the call light. R2 pressed the call light, NA-D entered, and NA-D assisted R2 with transferring from the recliner to wheelchair and wheelchair to toilet. NA-D stated, I was kind of confused because she usually doesn't call or ask for help. That's why I thought it was weird her light was on . I've never had her call for help getting up. During an interview on 3/18/25 at 2:10 p.m., NA-D stated she had never seen R2's call light on before and R2 had never called for help. NA-D stated R2 was independent with transfers. During an interview on 3/18/25 at 2:15 p.m., trained medication aide (TMA)-A stated R2 transferred independently and didn't ask for help. TMA-A noted R2 fell recently and we had to tell her you have to ask us [for help]. TMA-A stated R2 had only been toileting with staff assistance since her fall. On 3/18/25 at 3:28 p.m., registered nurse (RN)-A indicated R2 was normally independent with transfers even though the care plan indicated she needed assistance from staff. RN-A asked R2, You normally transfer yourself, don't you? Has someone been helping you transfer after your fall, or have you been moving yourself still? R2 replied, moving myself mostly, but sometimes I call for help. RN-A noted that after a fall, nurses filled out the paper fall packet with a checklist, fall investigation, and neurological checks and gave it to the DON. During an interview on 3/19/25 at 10:04 a.m., NA-C stated R2 was one assist for transfers and toilet use and did not have a toileting schedule. NA-C thought she probably kind of sneaks in there to the bathroom without us knowing to toilet on her own. I think ever since she came here she has done that. NA-C stated R2 recently fell in her bathroom at night in the dark while self-transferring and I guess really the only intervention is to encourage the call light . it would have been prevented if she had just had her call light on. During an interview on 3/19/25 at 10:15 a.m., NA-A stated R2 self-transferred and toileted independently during the day. She expressed concern that R2's memory has really been slipping. NA-A stated she thought R2 was okay to self-transfer independently. NA-A then checked the nursing assistant care sheet and noted R2 was identified as assist of one but stated R2 self-transferred most of the time. When asked how staff managed this self-transferring, NA-A stated, I don't know that it has even been addressed to be honest with you. Everyone knows she self-transfers. NA-A stated R2 was not a fall risk and there was nothing related to falls that staff needed to do for her. During an interview on 3/19/25 at 11:44 a.m., licensed practical nurse (LPN)-A stated she was aware of R2's recent fall and R2 was an assist of one but frequently transferred herself. LPN-A did not consider self-transferring to be a behavior. LPN-A stated R2 could read the 'call, don't fall' signs placed in her room but does she follow directions, no. LPN-A noted, we don't do a follow up on it after a new fall intervention is put in place and there was no re-assessment of an intervention's efficacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marks Living	400 15th Avenue Southwest Austin, MN 55912

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 3/19/24 at 12:58 p.m., R2 was sitting in the recliner in her room. R2 informed this surveyor that she needed to use bathroom, stated I think I can get into my [wheel]chair, and lowered the recliner legs. This surveyor asked R2 what she did if she needed to use the bathroom and R2 stated, I go by myself. This surveyor reminded R2 to press her call light for staff assistance. R2 pressed her call light, NA-A entered the room, and R2 stated I guess I've got to have help to get up she [this surveyor] says. NA-A then assisted R2 with transfer from recliner to wheelchair and wheelchair to toilet.

During an interview on 3/19/25 at 8:55 a.m., the DON stated fall paper packets were completed by nurses after a fall and were not part of individual resident medical records, they were part of the facility's fall investigation. She reviewed the packets upon completion. The DON stated nurses complete the root cause analysis of a fall by asking the 'five why's' outlined in the packet and then updated care plans with an appropriate intervention. The root cause analyses were reviewed at interdisciplinary team (IDT) meetings, but there was nowhere in the medical record that documents the packet has been reviewed and the root cause discussed and the packets are not completed consistently.

During an interview on 3/19/24 at 2:19 p.m., DON stated there was no causal analysis completed for R2's fall on 3/14/25. The DON stated she would expect it to be completed in the falls packet, transcribed into the EHR in a progress note, and identified on the care plan. DON stated the facility's incident report does not include a comprehensive causal analysis of the fall. R2 was one assist for transfers, she was unaware of R2's tendency to self-transfer, and noted R2 lacks safety awareness if she is transferring independently. DON confirmed the incident report's analysis of R2's fall failed to identify multiple predisposing factors and was not complete or accurate. DON confirmed the Morse Fall Scale dated 3/14/25 failed to identify R2's history of falls and impaired gait and was not accurate. The DON confirmed R2's falls care plan was not up to date or accurate. I can't really explain what the cause of her fall was and how that was determined. The DON further stated, We don't know that the intervention is appropriate, it is a 'call don't fall' sign. They don't work for people with cognitive impairment . clearly we're not doing the right thing for her. If the intervention is not appropriate, then it's not going to be measurable in terms of effectiveness.

R1

R1's face sheet dated 3/19/25, identified diagnoses of heart failure (condition in which heart doesn't pump blood as well as it should), diabetes mellitus (condition that affects how the body uses sugar as fuel), and atrial fibrillation (condition causing rapid heartbeat that commonly causes poor blood flow).

R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, no falls since admission, maximum assistance for all transfers, and on an anticoagulant.

R1's fall focus care plan dated 8/7/24, identified R1 was at risk for fall related to venous insufficiency and cellulitis to lower extremities. Goal to be free from falls. Interventions included: call light within reach/encourage use of call light for assistance as needed, ensure appropriate footwear during transfer, ambulation and/or mobilizing in wheelchair, routine safety checks, and adequate lighting.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER St Marks Living		STREET ADDRESS, CITY, STATE, ZIP CODE 400 15th Avenue Southwest Austin, MN 55912	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's fall record dated 2/19/25 at 3:30 p.m., identified R1 was found on floor lying on floor on left side. Skin tear on left elbow and bridge of nose. Immediate action taken was neurological exam, vitals, and skin assessment. Sent to emergency department (ED) for evaluation. R1's fall record did not include a comprehensive analysis of the fall nor identify a root cause of the fall. The record also included a fall packet checklist dated 2/19/25, included an incident root cause analysis form, however it did not identify a root cause of the fall and unsigned. R1's focus care plan initiated on 2/19/25, identified R1 had an actual fall with minor injuries related to poor balance on 2/19/25. Goal to resume usual activities without further incident. Intervention initiated on 2/19/25 of call, do not fall signs hung in room. R1's progress note dated 2/20/25 at 2:37 a.m., identified R1 returned from ED and did not find anything of concern with labs/testing. During an observation and interview on 3/18/25 at 1:28 p.m. R1 was seated in his recliner. R1's call light was laying over his bed, approximately 5 feet away from where R1 was seated. R1was observed to be itching on both arms and stated he needed a nurse. R1 asked this surveyor to get staff to help him, because he was unable to locate his call light to press. R1 stated, How am I supposed to ask for help if my call light is not here. Trained medication aide (TMA)-A and nursing assistant (NA)-B entered R1's room and applied lotion to bilateral arms and when completed as nursing assistant was going to leave the room, R1 asked NA-B if he could give him his call light before he left the room. During an interview on 3/18/25 at 3:21 p.m., registered nurse (RN)-A stated a residents call light should always be within reach to prevent further falls and reduce attempts to self-transfer. R3 R3's face sheet dated 3/19/25, identified diagnoses of history of falling, macular degeneration of left eye (eye disease that causes vision loss), heart failure, and emphysema (chronic lung disease that damages the lungs' air sacs). R3's significant change MDS dated [DATE], identified R3 had severe cognitive impairment and needed moderate as[TRUNCATED]