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	03/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify a physician for a change of condition for 1 of 3 residents (R3) who had a syncopal episode. Findings include:R3's diagnoses list dated 4/10/26 included pneumonia, acute respiratory failure, chronic heart failure, chronic kidney disease, atrial fibrillation, and syncope.R3's admission Minimum Data Set (MDS) dated [DATE] indicated no cognitive deficits.R3's health status note dated 4/4/26 at 9:09 a.m., trained medication assistant (TMA)-A reported on 4/3/26 R3 had passed out for a few seconds during a transfer. A nurse was notified and evaluated R3. In review of R3's record there was no indication the physician was notified. R3's care plan dated 3/26/26 indicated on 4/6/26 R3's transfer status was changed to assist of two for all transfers due to possible vagal response.During an interview on 4/10/2026 at 11:30 a.m., TMA-A stated on 4/3/26 she placed a gait belt on R3 then assisted him to a standing position. Upon rising, R3 started to lean forward, then went limp so TMA-A lowered him back into his recliner. After he sat down, his eyes opened, and he said hi. TMA-A immediately called for assistance over the walkie talkie. Licensed practical nurse (LPN)-A, LPN-B and registered nurse manager (RN-NM) responded to the call for assistance. During an interview on 4/10/2026 at 11:39 a.m., LPN-A stated on 4/3/26 at change of shift, TMA-A requested assistance in R3's room. LPN-A responded with LPN-B and RN-NM. R3 was alert when LPN-A entered the room. Because it was the end of her shift, LPN-A left the room with LPN-B and RN-NM caring for R3. LPN-A stated a provider should be updated any time a resident had a change in condition.During an interview on 4/10/2026 at 2:52 p.m., LPN-B stated on 4/3/26 she responded to a call for assistance in R3's room. When she entered, R3 was alert and following commands. LPN-B stated she did not check vital signs, did not update the provider and did not complete a nursing note because there was a lot going on that shift. LPN-B stated a note should be written and a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:46 a.m., RN-NM stated on 4/3/26 she responded to a request for help in R3's room. When RN-NM entered R3's room, R3 was alert and LPN-B was obtaining vital signs. R3 had not had an episode like that before at the facility. RN-NM stated there was no nurse's note about the event on 4/3/26 and no indication in the chart the provider had been notified. RN-NM stated a provider should be updated any time a resident had a change in condition. During an interview on 4/10/2026 at 11:05 a.m., director of nursing stated the provider should have been notified about the event the day it occurred because it was a significant change from R3's baseline. During an interview on 4/10/2026 at 9:51 a.m. medical doctor (MD) stated she learned of R3's dizziness episode on 4/8/26 through asking routine questions during rounds at the facility. MD would have wanted to be notified right away following the episode. The Change of Condition policy dated 2/2026 instructed to notify the physician in the event of a status change.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure residents at risk for or with pressure ulcers received ongoing comprehensive assessment, individualized reassessment of pressure-relief effectiveness, and revised interventions necessary to prevent deterioration and support healing forˆ3ˆof 3ˆresidentsˆ(R10, R4, R9) reviewed for pressure ulcers. This resulted in actual harm for R10 who had facility acquired stage 2 pressure ulcer on left sacral region (buttock) that deteriorated to a stage 3 pressure ulcer. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R10's face sheet dated 3/3/26, identified diagnoses of multiple sclerosis, diabetes, heart failure, neurogenic bladder and bowel, and chronic kidney disease. R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 was cognitively intact, no behaviors, no rejection of care, had impairment on both lower extremities, used a wheelchair, dependent to roll left and right, dependent for transfers, at risk for pressure ulcers, had no unhealed pressure ulcers, no venous/arterial ulcers, had moisture associated skin damage (MASD); used pressure reducing device for chair and bed, was not on a turning and repositioning program, had application of non-surgical dressings other than feet; and application of ointments/medications other than feet. R10's Braden Scale for Predicting Pressure Sore Risk dated 9/18/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions to elevate heels off bed, pressure reducing mattress on bed, pressure reducing pad in chair, turn and reposition while in bed.ˆ R10's Activity of Daily Living (ADL) focus care plan dated 9/4/21, identified R10 had a self-care deficit related to multiple sclerosis (MS) and MS complications. Goal to be clean and well groomed. Interventions as follows:ˆ -Transfers: dependent on two staff (dated 5/14/25). -Bed mobility: dependent on staff for repositioning and turning in bed (dated 12/16/25). R10's skin integrity focus care plan revision date of 12/16/25, identified R10 had potential/actual impairment to skin integrity with fragile skin related to limited mobility and moisture associated skin damage (MASD). Goal to be free of any skin related infection.ˆ Interventions as follows:ˆ -Elevate heels off bed (dated 11/24/21). -Skin barrier cream/ointment to protect skin as needed (dated11/24/21). -Pressure reducing pad while in chair (dated 6/21/24). -Have resident lay down one hour every shift to relieve pressure off peri area. Start 4/11/25. -Avoid pulling buttocks open with care and treatment (dated 9/24/25). -Nutrition supplements as ordered for wound healing (dated 9/24/25). -Provide peri care two times (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	per shift on days and evening (dated 9/24/25). -Reposition every hour while in chair (dated 9/24/25). -Turn and reposition while in bed every two hours (dated 9/24/25). Review of R10's Skin Assessments dated 9/19/25, 9/26/25, 10/3/25, 10/10/25, 10/24/25 (completed 14 days after last assessment) identified R10 had redness to bottom/skin breakdown on each of the assessments. R10's assessments did not identify location, measurements, wound type, nor any other wound characteristics. R10's physician orders identified the following: -Wound left buttocks: wash per facility protocol, pat dry, apply zinc oxide (a medical cream to treat skin irritations) ointment twice daily for 14 days; after 14 days apply barrier cream to wound until resolved twice daily. Start date 8/15/25 with end date of 11/19/25. R10's Skin assessment dated [DATE], identified left buttocks had healing popped blisters. Mepilex (foam dressing) had been applied. No other wound characteristics including measurements, wound integrity, and location on the buttock were included. R10's record did not identify a corresponding physician order for the treatment of the foam dressing. However, physician order dated 11/8/25 directed alternating pressure air mattress; a full 30 degrees turns side to side every 2 hours while in bed; reposition every hour while in bed; cushion to chair -such as ROHO (air filled pressure-relief cushion) when in wheelchair; elevate heels while in bed. R10's Skin assessment dated [DATE], identified a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm. R10's assessment did not identify any description of the wound characteristics. Corresponding progress note included a situation, background, assessment, and response (SBAR) had been sent to physician indicating R10 had a stage 2 pressure ulcer on left buttocks that measured 2.0 (cm) x 1.0 cm with partial thickness loss of skin, skin was pink, had a moist wound bed with fragile surrounding skin. No further characteristics was identified. R10's record reviewed 11/14/25 through 11/16/25 did not include an order for wound care treatment for the identified stage 2 pressure ulcer. R10's nurse practitioner note dated 11/17/25, identified R10 had a stage 2 pressure ulcer on her left buttocks that continue to be open despite nursing care. R10 used a ROHO cushion but unfortunately the ROHO was placed backwards. R10's physician orders^dated 11/17/25, included the following: -Left buttocks wound to wash with wound cleanser, scrub the wound bed, apply Duoderm Signal (a name brand dressing that signals when it is time to be changed) dressing to wound bed, change every 3rd day or as needed if dressing peels off. Start date 11/17/25. -Apply zinc oxide twice daily to skin surrounding left buttocks wound to act as barrier for incontinence. Do not scrub the zinc oxide off but reapply twice a day for incontinence. Start date 11/17/25. R10's Skin Assessments dated 11/21/25, 11/28/25, and 12/5/25, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Braden Scale for Predicting Pressure Sore Risk dated 12/10/25, identified R10 was at moderate risk for developing pressure ulcers due to being slightly limited to respond to pressure-related discomfort; skin is occasionally moist; being chairfast; being very limited with mobility; having a problem with friction and shear. Interventions as follows: -Elevate heels off bed. -Pressure reducing pad while in chair. -Pressure reducing mattress on bed. -Skin barrier cream/ointment to protect skin as needed. -Turn and reposition while in bed every 2 hours. R10's nurse practitioner nursing home visit note dated 12/13/25, included an order to discontinue all prior wound buttocks wound treatments and new order for buttocks wound treatment of zinc barrier cream mixed with collagen powder twice daily and as needed for incontinence. The visit note did not include wound status and/or characteristics. R10's Skin Assessments dated 12/12/25, 12/19/25, 12/26/25, 1/2/26, and 1/9/26, identified R10 had a stage two pressure ulcer on left buttocks measuring 2.0 cm x 1.0 cm (which was the same measurement of wound for each assessment). R10's assessments did not any other wound characteristics except being marked as improving. R10's Skin Assessments dated 1/17/26 indicated no change to the size of the stage two pressure ulcer on the left buttock since 11/14/25. The assessment identified the stage 2 ulcer with measurements 2.0 cm x 1.0 cm., marked as improving. No other wound characteristics were included. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R10's nurse practitioner (NP) note dated 1/21/26, identified R10 was seen for wound care management. R10 had a stage 3 pressure ulcer on left buttocks near the crease. Original size was 1.7 cm x 1.0 cm x 0.2 cm with current size of 2.0 cm x 3.6 cm x 0.1 cm. Edges distinct and epithelization. Wound bed with granulation and epithelization. Minimal serous (clear and watery) drainage. Tender and not odor present. Periwound with blanchable erythema. Identified current physician orders as wash per facility protocol, pat dry, apply foam dressing, change every 3rd day and as needed for rolling/soiling. Do not apply barrier cream with collagen powder to wound. -Zinc powder with collagen powder on other perianal wounds twice daily and as needed. -Do not scrub or wash barrier cream off when soiled. -Encourage repositioning every 2 hours while in bed to offload pressure. -During the day encourage R10 to lay down for at least 60 minutes at a time to offload pressure at least twice daily. If R10 does not want to lay down at least verify R10 is clean and dry and reposition in wheelchair. In review of R10's record between 11/14/25 when the stage 2 pressure ulcer was first identified through 1/21/26 when the NP identified the ulcer had deteriorated to a stage 3 , there was no indication the existing pressure relieving interventions were evaluated for effectiveness, and no new interventions were added . Additionally, R10's record did not include a comprehensive assessment that identified R10's skin tolerance to pressure over time; it could not be ascertained how every two-hour positioning schedule first initiated on 9/24/25 (prior to ulcer development) was appropriate or effective. R10's physician order dated 1/22/26 directed for other sacral wounds apply zinc barrier cream mixed with collagen powder twice daily and as needed. Do not apply where dressing for left buttocks wound cut. The transcribed order did not direct the application of the foam dressing changed every 3rd day. Review of R10's January and February 2026 TAR included the physician order that had been transcribed without the foam dressing. The TARs indicated R10's wound treatments were completed without using the foam dressing according to transcribed order. R10's Skin assessment dated [DATE], 1/30/26, 2/6/26, 2/13/26, 2/20/26, and 2/27/26 did not identify the correct staging of the ulcer according to the nurse practitioner instead the assessment identified a healing stage 2 pressure ulcer to left buttocks measuring 2.0 cm x 1.0 cm indicating the wound remained the same size since first identified on 11/14/25. The assessment did not include any wound characteristics. In review of R10's record between 11/15/25 through 2/27/26 revealed R10's record did not include weekly comprehensive skin assessments and even though the TAR directed wound monitoring for any wounds for changes was completed (denoted by check marked boxes) and treatments were completed according to orders (denoted by check marked boxes) that were transcribed, there was no documentation of wound status and characteristics. R10's nursing home nurse practitioner note dated 2/28/26, identified R10's pressure injury stage 3 to left sacral region had resolved. During an interview on 3/2/26 at 12:18 p.m., R10 was in her room seated in her wheelchair. R10 explained she had a sore on her bottom but believed it was getting better. R10 stated when she was in bed, staff did come in at night to reposition her every 2 hours. R10 explained in the morning once she got up for the day, she spent most of her time in her electric wheelchair that could lean back this helps me get off my bottom. R10 then used her controls on her wheelchair to lean back in her chair 45-degree angle which although redistributed the amount of weight from R10's bottom did not completely offload all of her weight from her bottom. R10 stated sometimes she could not tell if her bottom was getting sore because of her MS, this may be why I got a sore on my bottom. R10 further stated staff did not come into her room to give her direction to reposition while in her chair, so she tried to remember to do it herself, but sometimes forgets. R10's wheelchair had a ROHO cushion on it with the words FRONT on the front of the cushion. R10 stated that the aides had put this wording on the front of the cushion, because staff kept putting the cushion in her chair backwards. R10 stated if her cushion was backwards her bottom worse if not placed correctly. R10 was unaware how long ago the wording was added to the cushion. During an interview on 3/2/26 at 12:34 p.m., trained medication aide (TMA)-C stated R10's wheelchair allowed her to reposition herself in her chair if she felt the need to get off her bottom. TMA-C was unaware R10 was supposed to be repositioned every hour in her chair and was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	not sure if staff were supposed to remind R10 to reposition in her chair. During an interview on 3/2/26 at 12:38 p.m., nursing assistant (NA)-D stated was she responsible for caring for R10 today but was unaware R10 was supposed to lay down in bed for one hour and was unaware R10 needed to be repositioned every hour while in her wheelchair. NA-D stated once R10 was in her recliner she would notify staff when she wanted to be checked and changed. During the day R10 spent the majority of the time in her wheelchair and did not like to lay in her bed. R10's electric wheelchair reclined to different positions which R10 would do that herself, however, staff did not track how often R10 repositioned. NA-D was not able to articulate how R10's chair was able to take pressure off her bottom. NA-D further explained R10's the chair reclining would not be considered offloading her bottom; R10 would have to be completely off her bottom. During an interview on 3/2/26 at 12:40 p.m., licensed practical nurse (LPN)-C stated R10's left buttocks wound had not had an order for a foam dressing since 1/21/26, the wound has been treated with mixing collagen powder with zinc oxide twice a day even though the physician order directed the use of one. LPN-C explained this order should have been clarified with the nurse practitioner before it had been removed off of the orders. LPN-C indicated even though the treatment order was not followed, R10's wound had been healing. During an interview on 3/2/26 at 3:07 p.m., registered nurse manager (RN-NM) stated R10's pressure ulcer on her left sacral region was facility acquired and developed on 11/14/25. RN-NM reviewed R10's skin assessments from 1/22/26 through 2/27/26 and believed the assessments were inaccurate with measurements since R10's left buttocks pressure ulcer as healed on 2/28/26. RN-NM also identified R10's weekly skin assessments were not considered comprehensive. RN-NM was unaware the pressure ulcer was first identified as a stage 2 pressure ulcer and then had deteriorated to a stage 3 pressure ulcer. RN-NM stated R10 was supposed to be turned and repositioned every 2 hours in bed and every hour in her wheelchair R10 has MS and is not able to feel when she may be having buttocks pain RN-NM was now aware that direct care staff were relying on R10 to reposition herself when she was in her wheelchair. RN-NM explained R10's every 2-hour turning and repositioning was given as an order by the nurse practitioner; RN-NM was not aware if the frequency was appropriate or effective. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated she was unaware R10's pressure ulcer on her left buttocks had deteriorated to a stage 3 pressure ulcer on 1/21/26. R10's wound staging should have been identified as stage 3 since 1/21/26 remained at stage 3 until the wound had been determined it had healed. On 3/2/26 at 1:05 p.m. and 3:45 p.m., attempted to contact R10's nurse practitioner responsible for her pressure ulcer care, however, did not get a return phone call. R4 R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact, had no behaviors, no rejection of care, no range of motion limitations on upper or lower extremities, need substantial/maximum assistance for rolling side to side, was dependent for sit to stand, dependent for chair to bed, at risk for pressure ulcers, no unhealed pressure ulcers, had MASD, treatments of pressure reducing device in chair and bed, application of nonsurgical dressings and ointments. R4's ADL focus care plan revised on 12/27/25, identified R4 had a self-care deficit related to weakness, history of stroke, cancer of the pancreas and liver, and diabetes with neuropathy (a type of nerve damage that happens with diabetes). Goal to improve current function in ADLs. Interventions as follows: -Bed mobility extensive assistance of two staff to turn and reposition in bed. -Partial assistance of two staff with a sit to stand mechanical lift for transfers. R4?s skin integrity focus care plan revised on 1/7/26, identified R4 had a potential/actual impairment to skin integrity with old scarring from previous pressure injuries on bilateral buttocks related to incontinence of urine and stool. Goal to free from skin related infection. Interventions as follows: Wound/Skin treatment as ordered (date 12/18/25). -Use a draw sheet of lifting device to move resident (date 12/18/25). -lotion dry skin areas as necessary (date 12/18/25). -Skin barrier cream/ointment to protect skin as needed (date 12/18/25). -Pressure relieving/reducing pad while in chair (date 12/18/25). -Pressure reducing (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	mattress on bed (date 12/27/25). -Assist with offload every two hours in bed and chair (date 12/27/25). R4's nursing home visit nurse practitioner note dated 12/22/25, identified R4 had been admitted with a wound to left buttocks (the note did not identify type of wound nor wound characteristics including measurements). The note included orders to cleanse wound with wound cleanser, pat dry, apply small amount of Iodosorb (antimicrobial gel directly to open wound area, cover with dry gauze and secure with foam dressing. R4's progress note dated 1/19/26, identified a situation, background, assessment, response (SBAR) was sent to physician that wound to buttocks in now open and bleeding. Buttocks has keloid skin to the right and skin tags that had an open area and the left had an open area as well. Asked for new treatment for the wound. The note did not include any further description of the wound. R4's physician orders dated 1/20/26, identified order to buttocks wounds as follows: -Wash per facility protocol and pat dry. Cover with silicone bordered foam dressing and change every 3rd day and as needed for rolling or getting soiled. (Start date 1/20/26 through 2/9/26). -Buttocks wounds peel dressing back to assess wound once daily. Start date 1/20/26 through 2/9/26) R4's Skin assessment dated [DATE], identified R4 had non-blanchable redness to the right buttocks near the gluteal cleft and bilateral buttocks had red/purple discoloration that was blanchable. Left buttocks had 1.2 cm x 1.2 cm open area. Corresponding progress note dated 2/3/26 included R4's bottom was starting to look macerated with non-blanchable redness noted to the right buttocks near the intragluteal cleft. R4's nursing home nurse practitioner note dated 2/6/26, identified a stage 2 pressure injury to the left medial buttocks and incontinence associated dermatitis. Pressure ulcer had three small open wounds on the left buttocks close together measuring 1.0 cm x 1.0 cm x 0.1 cm. More proximal (center of the body) on the left buttocks measures 1.5 cm x 1.0 cm x 0.1 cm. Edges attached and open. Wound bed denuded (loss of top layer of skin), fragile, and non-blanchable erythema. Minimal bloody drainage and tender with no odor. Periwound fragile and pink. Ulceration had gotten larger. Treatment orders as follows: -Wash buttocks wound per facility protocol, pat dry, cover with silicone bordered foam dressing, peel back daily to assess daily and change every 3rd day and as needed rolling/soiling. R4's Skin assessment dated [DATE], identified R4 had thick scar tissue with 1.2 cm x 1.2 cm open wound to the left buttocks, with red/purple discoloration that is blanchable. Treatment orders in place. The assessment did not include further description of the wound nor address the second wound as identified by the NP. R4's Skin assessment dated [DATE], identified R4's left buttocks had thick scar tissue with 1.2 cm x 1.2 cm open wound to left buttocks. Bilateral buttocks had red/purple discoloration that was blanchable. Identified as healing. No further description was included. Review of R4's record from 2/14/26 through 2/25/26 did not include a comprehensive wound assessment had been completed of R4's buttock wounds. During an observation and interview on 2/25/26 at 10:10 a.m., R4 was lying in a bed on top of a deflated air mattress that had been unplugged. There was no other barrier between the metal bedframe and the plastic material of the mattress. NA-C and NA-D entered R4's room, NA-D stated R4's air mattress was totally deflated and must have been unplugged by accident. NA-D was unsure how long R4's mattress had been unplugged or when the last time R4 had been turned and repositioned in bed. NA-D then plugged R4's air mattress back in the outlet. R4 was assisted by NAs to stand up using a sit-to-stand lift exposing the back of R4's incontinent brief which had a silicone foam dressing stuck on the right side. NA-D stated, How did that get there?, it is supposed to be on his wound on his bottom. As NA-D removed R4's brief an open wound was observed on R4's right buttock that was approximately 2.0 cm x 1.0 cm in size. The wound had uneven edges and was macerated (white, soft, wrinkled skin due to excessive moisture). Base of the wound was pink and R4 denied pain in the area. R4's bilateral buttocks had thick skin that was light brown (hyperpigmentation) in color with no redness or purple noted. NA-D stated R4 was going to get a shower, then the nurse would check his skin and apply a new dressing. During an interview on 2/25/26 at 10:45a.m., RN-B stated she had been told earlier that R4 had a new open area on his right buttocks and needed to put a dressing on it. RN-B explained that by R4's air mattress being deflated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	for an unknown time this could cause injury to R4's bottom. RN-B indicated she was not responsible for completing the comprehensive wound assessments, the nurse managers completed them. R4's Skin assessment dated [DATE], identified R4 had moisture associated skin damage (MASD) to left buttocks measuring 2.5 cm x 1.0 cm; stage 2 pressure injury to right buttocks measuring 2.5 cm x 1 cm; and bilateral deep tissue injury measuring 9.0 cm x 8.0 cm. Wound identified as worsening. Assessment did not identify any further details of the pressure injury. R9 R9's face sheet dated 3/1/26, identified diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's significant Change MDS dated [DATE], identified R9 had intact cognition, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was dependent for chair/bed to chair transfers, was at risk for developing pressure ulcers, had one stage 2 pressure ulcer, R9's Braden Scale for Predicting Pressure Sore Risk dated 1/26/26, identified R9 was moderate risk for developing pressure ulcers due to being slightly limited in sensory perception, being occasionally moist, chairfast, completely immobile, problem with friction/shear. R9's ADL focus care plan revised on 5/21/25, identified R9 had a self-care deficit related to weakness, respiratory failure, and kidney failure. Goal to maintain current level of function. Interventions as follows: -Transfers: dependent with assist of two staff using a full body mechanical lift. -Bed mobility: dependent with one to two staff for repositioning and turning in bed. R9's pressure ulcer focus care plan dated 5/21/25, identified R9 had potential for pressure ulcer development related to history of ulcers and immobility. Goal to have intact skin. Interventions as follows: -Assist of two staff to turn and reposition every 2 hours in bed and chair, more often as needed or requested. Pressure relieving mattress on bed (dated 2/16/19). -Pressure reducing device on wheelchair (dated 12/16/19). -Lay resident down between meals and prop to either side using pillows to fully offload buttocks. If refused report to the nurse (dated 1/28/26). -May leave lift sling under due to discomfort with removing and replacing. Skin checks increased to twice per week (dated 1/28/26). R9's Skin assessment dated [DATE], identified left buttocks wound with an open area that measured 0.5 cm x 0.5 cm, no drainage, center is red in color. Mepilex dressing applied. The assessment did not include any other characteristics. R9 nurse practitioner nursing home visit note dated 1/13/26, identified R9 had been having severe pain in buttocks for past 3 weeks with pain relieved by lying flat in bed. Stage 2 pressure ulcer on left buttocks identified. Treatment orders to wash per facility protocol, pat dry, cover with silicone bordered foam dressing, change every 3rd day and as needed and frequent repositioning and offloading pressure. In review of R9's record despite the order for frequent repositioning/offloading there was no indication of a comprehensive assessment to determine the frequency of repositioning nor evident the care plan was revised with a change from every two hour positioning which was identified as an intervention on 2/16/19. Review of R9's Skin Assessments dated 2/3/26 through 2/21/26 indicated the measurements of the left buttock wound remained the same. The assessments each identified a wound with an open area that measured approximately 1.3 cm x 0.75 cm. Area cleansed and patted dry, skin prep and bordered foam dressing applied on each assessment. The assessments did not include any other wound description or characteristics. R9's Skin assessment dated [DATE], indicated the wound to the left buttock had deteriorated. The assessment included the wound had an open area, wound bed appears superficial, pink/red in color, no drainage, measures 2.5 cm x 3.0 cm. New bordered foam dressing applied. The assessment did not include any other wound description or characteristics. R9's Weekly Wound/Complex Wound Observation Tool dated 2/27/26, identified R9 had a stage 2 pressure ulcer on left buttocks that measured 0.8 cm x 1.6 cm with no depth. Wound was acquired while in the facility. - During an interview on 3/2/26 at 12:40 p.m., LPN-C stated R9 was turned and repositioned every 2 hours while in bed and the chair, which he allows. R9's wound on his left buttock has been improving with turning and repositioning and treatments. LPN-C further explained that the skin assessments that were done on bath days were not comprehensive assessments because many of them were completed by LPN's and not an RN. LPN-C was unsure which registered nurses was responsible for the assessments and (continued on next page)

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	245369	A. Building B. Wing	03/02/2026

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	staging of a wound. During an interview on 2/26/26 at 2:06 p.m., Minimum Date Set Coordinator Registered Nurse (MDS-RN) stated she had noticed a while ago that residents with pressure ulcers had not had a weekly comprehensive wound assessment of their wounds completed and had informed her concern to upper management, but continued to notice that the comprehensive assessment have not been completed. During an interview on 3/2/26 at 3:07p.m., RN-NM stated she had not been performing any comprehensive assessments of residents with pressure ulcers and was not aware that a registered nurse needed to complete the comprehensive assessment each week. RN-NM explained she had not been given directions to be responsible for completing the wound assessment for the residents with pressure ulcers; the only direction she received to ensure the weekly bath skin assessments by the floor nurses. RN-NM further explained she had not received any wound assessment education and without having this education she would not feel comfortable performing the assessments also RN-NM believed that any staff could assess the wounds and was not aware a registered nurse would need to complete the assessment to ensure it was correct and appropriate treatments and pressure reducing measures were in place. During an interview on 3/2/26 at 11:05 a.m., director of nursing (DON) stated registered nurse manger (RN-NM) had been assigned the responsibility of ensuring the weekly pressure ulcer assessments were being completed. DON explained when she started reviewing wound documentation she realized the weekly skin bath audits were completed however, not the comprehensive wound assessments. Any resident with pressure ulcers should have had a weekly comprehensive registered nurse (RN) assessment of the wounds to ensure the appropriate treatment and pressure prevention measures were in place. The comprehensive assessment should have included: type of wound, location, date acquired, staging, length, width, depth, description of wound base, edges, and drainage. DON reviewed R10, R4, R9's record and identified no RN weekly comprehensive wound assessments had been completed since identification of the pressure ulcers and they should have been completed. DON explained the purpose of the comprehensive assessment being done by an RN would be to ensure the pressure ulcers are assessed for healing and/or deterioration and to ensure proper pressure relieving measures/treatments are in place. Review of the facility's Prevention and Treatment of Skin Breakdown Policy undated, identified it was the policy of the facility to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Procedure as follows: Skin Ulcer Data Collection & Assessment sheets are used for pressure, stasis, arterial and neuropathic ulcers. Data is provided by the floor nurse or nurse manager on resident's bath day. RN assesses the information and writes a progress note detailing the wound appearance, treatment, and healing progress. Treatment orders to be followed as MD prescribes, measurements of wounds only need to be documented weekly. If wound worsens consecutively for 2-3 weeks a note to the MD is sent with request for new orders. Prevention of Pressure Ulcers A. Braden Scale* and Comprehensive Risk Data Collection form (which includes a skin audit) will be done: Upon admission Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, Change in cognition, nutrition, etc.). Please see Policy and Procedure for Braden Scale & Comprehensive Risk Data Collection in the Forms and Care Plans section for instructions. A. Turning and Repositioning Observation (capturing turning & repositioning). Pressure is the primary cause of pressure ulcers. An effec[

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview and document review the facilityˆfailed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4 and R9) reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed toˆcomprehensively investigate/analyze falls for root cause, implementˆappropriate interventionsˆto prevent and/or reduce the risk for future fallsˆfor 1 of 3 residents (R3) reviewed for falls/safety. The IJ began onˆ2/25/26,ˆwhen nursing assistant (NA)-C and NA-D had to be stopped from using the wrong harness size according to R4's care plan and the failed to follow manufacturer's instructions to tighten the harness torso strap to ensure safety putting R4 at likelihood for serious harm/injury or death. ˆThe administrator and director of nursing (DON) were notified of the immediate jeopardy on 2/26/26 at 6:08 p.m. The immediate jeopardy was removed onˆ3/2/26 at 2:30 p.m.,ˆbut non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy.ˆ Findings include: R4's face sheet dated 2/27/26, identified diagnoses of heart failure, chronic kidney disease, neoplasm (cancer) of the pancreas, diabetes, osteoarthritis, and history of falling. R4's admission Minimum Data Set (MDS) dated [DATE], indicated R4 did not have cogntive impairment, had no behaviors, no rejection of care, no range of motion limitations on upper or lower extremities, was dependent for sit to stand, and was dependent on staff for chair to bed transfer. Additionally, R4 had a fall in the last month prior to facility admission, had a fall within the last 2-6 months since admission with no injury, and had one fall since admission with injury. R4's Morse Fall Scale (a tool used to determine risk of falling) dated 12/18/25, identified R4 as a high-risk for falling due to weakness and history of falling.ˆ R4's Therapy Recommendation form dated 12/18/25, identified R4 needed assistance of two staff with the sit-to-stand mechanical lift for all transfers with large harness due to needing cues for hand placement.ˆ R4's fall focus care plan dated 12/27/25, identified R4 was at risk for falls related to history of falls before and after admission. Goal to be free from falls. Interventions dated 12/18/25 as follows: -Call light within reach. Encourage use of call light for assistance as needed. -Ensure resident is wearing appropriate footwear (non-skid socks or rubber soled shoes) during transfer, ambulation and/or mobilizing in wheelchair. -In the event of fall, resident will need assistance of two staff with a total mechanical lift and a large sling. ˆ-Routine safety checks. -Follow facility fall protocol. R4's Activity of Daily Living (ADL) focus care plan initiated on 12/18/25, identified R4 had an ADL self-care performance deficit related to weakness, history of stroke, cancer of the pancreas, and diabetic with neuropathy (damage to the nerves resulting in pain, numbness, tingling, or weakness especially in the hands and feet). Goal to improve current level of function in ADLs. Interventions dated 12/19/25 directed staff for toilet use: R4 required assistance from two staff for all transfers with a sit to stand mechanical lift and for transfers R4 required assistance from two staff members for all transfers. ˆ R4's nurse aide resident care sheet dated 12/21/26, identified R4 needed assist of two staff with the sit-to-stand mechanical lift with a large harness.ˆ During an interview on 2/25/26 at 7:45 a.m., trained medication aide (TMA)-B explained staff would use the therapy recommendation or the paper care sheet (not the care plan or kardex (abbreviated care plan)) to determine what size harness a resident required when using the sit-to-stand lift. R4's progress note dated 12/21/25 at 1:56 p.m., identified the nurse was called to R4's room and found that R4 had fallen from the sit-to-stand mechanical lift. R4 was lying on the floor with his feet still on the sit-to-stand with the leg strap still buckled and his head resting on the recliner. Isolated incident care plan was not followed by nursing assistant and was transferred by one person using the sit-to-stand (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mechanical lift. ^Noted a friction bruise that was reddish in color under left armpit from the sling. R4 was changed to a total mechanical lift until therapy can re-assess. Educated staff on importance of following care plan and two staff for cares and transfers. R4's record did not identify the size of sling used and not evident a comprehensive assessment was completed to determine sling size for the full body mechanical. Additionally, the care plan was not revised to include intervention(s) for R4 falling asleep in the lift. R4's fall incident report dated 12/21/25 at 12:23 p.m., identified R4 had a witnessed fall from the sit-to-stand mechanical lift.^Writer witnessed the patient lying on the floor with his feet still in the^sit-to-stand mechanical lift^with leg strap still buckled, head propped up on the footrest of the recliner, which was down at the time.^Resident description was that R4 felt weak and let go of the^sit-to-stand mechanical lift^and his arms went up and he fell. R4's Fall Root Cause Analysis and Witness Statement form dated 12/21/25, identified R4 was supposed to have two staff members for all transfers with the sit-to-stand however, according to witness statement the nursing assistant attempted transfer by herself from wheelchair to the recliner while R4 fell asleep during transfer and fell. R4 felt weak and arms went up when he let go of the sit to stand mechanical lift and fell. During an interview on 2/26/26 at 11:06 a.m., nursing assistant (NA)-E stated on 12/21/26, R4 had asked for a brief change and wanted to be transferred from his wheelchair to his recliner. NA-E stated she was aware R4 needed two staff to transfer using the sit-to-stand mechanical lift, so she had requested assistance over the walkie talkie but did not get a response. NA-E stated she had not verified R4's care plan/care sheet and/or therapy sheet to see what size sit-to-stand harness R4 was supposed to use. NA-E stated with conviction she was 100% positive she used an extra-large [XL] harness to transfer R4, because R4 was the only resident using the sit to stand lift in that unit and staff kept the sling at all times on the lift. NA-E then proceeded to transfer R4 by herself. NA-E stood R4 in the sit-to-stand mechanical lift, performed pericare as R4 stood up, pulled R4's pants back up, and then turned and then pushed the lift towards the recliner. Once in front of the recliner R4 began to fall asleep, he let go causing him to slip completely out of the lift harness onto the ground. Review of the facility investigation notes identified NA-E was not contacted until 12/22/25 by an unknown staff member. On 12/22/25 NA-E stated she was aware R4 needed assist of two staff with the sit to stand lift, but other staff were busy, so she needed to get R4 cleaned up and moved. NA-E informed DON she had checked R4's care plan and verified harness size (notes did not identify what size harness NA-E used at the time of the transfer), attached the harness and buckled R4's feet and decided to then lift R4 up in the lift. NA-E cleaned and changed R4's pad and then was going to transfer R4 to the recliner but when NA-E was positioning R4 near the recliner, R4 slipped out, fell to the ground. R4 told NA-E he had fallen asleep and she then called the nurse. During an interview on 2/26/26 at 12:02 p.m., licensed practical nurse (LPN)-C stated on 12/21/25 at around 12:30 p.m. she had been called to R4's room by NA-E over the walkie talkie to report R4 had fallen from the lift. Upon entering R4's room she found R4 sitting on the floor in front of his recliner with both of his legs still resting on the lifts' foot plate with the calf strap still buckled. The harness was still connected to the lift with the torso strap still buckled; the harness was connected to the lift appropriately. LPN-C had not verified that R4's harness was the correct size after the fall, I did not even think to check. LPN-C explained she thought R4 fell out of the lift because NA-E had not cinched the torso strap tight so when R4 let go he slipped completely out of the harness. LPN-C further stated R4 had pain in his left shoulder for some time after the fall which was treated with pain cream. During an interview on 2/26/26 at 12:44 p.m., the Director of Nursing (DON) stated she was notified on 12/21/25 that R4 had fallen from the sit^to^stand lift. Following the notification, the DON immediately removed NA^E from the work schedule. She reported attempting to interview NA^E shortly after the incident but was unable to reach her at that time. DON returned to the facility later that afternoon, inspected the lift and harness, and noted no apparent defects. She reported she was not aware that an XL harness had been used during the transfer; she believed a large sling had been used but had no documentation verifying the harness size at the time of the fall. DON interviewed NA^E on 12/22/25. During that interview, NA^E (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported she had transferred R4 alone and did not utilize a second staff member as required by policy and the resident's care plan. NAˆE had stated that R4 fell asleep during the transfer, released her hold on the equipment, and subsequently slipped out of the sling. DON reported she did not recreate the incident with NAˆE to determine the cause of the fall and did not have documentation of any postˆincident inspection of the lift or harness. DON kept NAˆE off the schedule until NAˆE completed a repeat competency test on the safe use of mechanical lifts. DON reported conducting multiple competencies and audits on NAˆE only and acknowledged she did not perform audits or provide additional staff education regarding adherence to care plans for any other staff members. DON stated she did not believe improper lift use was a systemic issue and therefore limited education and competency review to NAˆE. R4's progress note dated 12/22/25, identified R4 was complaining left shoulder was sore.ˆ R4 pointed to left shoulder and had an ache and with range of motion (ROM) had pain.ˆ R4 was seen by nurse practitioner virtually and no x-ray ordered.ˆ R4's nurse practitioner note dated 12/22/25, identified R4 was seen due to pain in left shoulder following a fall from the sit-to-stand mechanical lift on 12/21/25. Physician order forˆVoltaren (pain cream)1% gel; Apply 2 g topically 4 (four) times a day. May also apply 2 grams four times a day as needed (shoulder pain). R4's Medication Administration Record (MAR) reviewed 12/23/25 through 1/5/26 identified Voltaren cream had been applied to R4's left shoulder 14 times. R4's care plan revised on 2/24/26, identified R4 required assistance from two staff using sit-to-stand mechanical lift.ˆ R4's resident care guide reviewed on 2/25/26, identified R4 needed assist of two staff with sit-to-stand mechanical lift with a large harness. During an observation and interview on 2/25/26 at 9:31 a.m., NA-C and NA-D entered R4's room to assist R4 with transfer from bed to shower chair.ˆ NA-D brought in a sit-to-stand mechanical lift with a harness draped over the top of the lift.ˆ NA-D stated R4 was the only resident on the wing that used the sit-to-stand lift and that his (XL) harness was draped over the lift. NA-D stated twice the XL was the correct size for R4.ˆ NA-C and NA-D then sat R4 at the edge of the bed and placed the XL harness behind R4's back.ˆ Surveyor intervened and asked NA-C and NA-D to verify that the XL harness size was the correct size to use with R4. Neither NA-C nor NA-D had a resident care guide that identified R4's correct harness size.ˆ NA-D left the room to find out the correct harness size R4 was supposed to use and returned to R4's room with a large harness. NA-D stated she verified R4's resident care guide and it identified R4 was to use a large harness not an XL. NA-D stated she had to go to another wing in the building to find the correct harness size for R4, because the size was not in R4's unit. Registered nurse (RN)-A then entered R4's room and stated R4 had been assessed by therapy and was suppose to be using a large harness, RN-A stated R4's care plan/kardex did not identify harness size , but the resident care guide did specify the correct size and staff should be checking in all places to verify they are using the correct harness. NA-C and NA-D then placed the large harness behind R4's back, applied the loops, provided cues to have proper hand placement to R4, attached the leg and torso strap, had R4 stand. As R4 stood, NA-C nor NA-D cinched the torso strap. Surveyor intervened to instruct NA-C and NA-D to cinch the torso strap as R4 stood. NA-C stated she was aware the torso strap needed to be cinched as a resident stands up, but must have just overlooked doing it. NA-C stated a resident could fall out of the lift if this is not done each time they stand up and she should have made sure this was done. NA-C and NA-D stated they had not received any re-education on the proper use of mechanical lifts nor following care plan since their initial orientation. During an interview on 2/25/26 at 10:30 am., director of nursing (DON) verified R4's care plan/Kardex did not identify R4's harness size staff are supposed to use during a transfer with a sit to stand lift. DON stated R4 was supposed to be using a large harness and it had been identified on the resident care sheet, but should have been added to the care plan/Kardex. DON stated staff were supposed to use the Kardex and/or resident care guides to verify correct harness size prior initiating a transfer with the lifts. During an interview on 2/26/26 at 4:26 p.m., medical director (MD) stated any resident being transferred using a mechanical lift without a care plan and/or policy followed for use of the mechanical lift had the likelihood to cause serious harm, serious injury, or even death in the event (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident falls from the mechanical lift.ˆ R9 R9's face sheet dated 3/1/26, identified R9 had diagnoses of heart failure, chronic respiratory failure, and chronic kidney disease. R9's Significant Change MDS dated [DATE], identified R4 was cognitively intact, had no behaviors, no rejection of care, had impairment of range of motion on both lower extremities, used a wheelchair, was dependent for chair/bed to chair transfers. R9's Mechanical Lift Sling/Harness Sizing assessment dated [DATE], identified R9 needed a large sling for the total mechanical lift.ˆ R9's ADL focus care plan dated 5/21/25, identified R9 had a self-performance deficit related to weakness, chronic respiratory failure, and schizophrenia.ˆ Goal to maintain current level of functioning.ˆ Interventions as follows for transfers: -EZ stand harness size large (R9 did not use an EZ stand lift); Total mechanical lift sling: (was left blank). Dated 2/27/26. -Transfer: The resident requires total dependence on two staff for transferring via total mechanical lift with an XL sling. Dated 1/8/26.ˆ R9's Kardex reviewed on 3/2/26 at 10:00 a.m., identified R9 needed a XL sling for with the total mechanical lift, however, this conflicted with the assessment dated [DATE] that identified R9 required a large sling. During an interview on 3/2/26 at 10:14 a.m., DON reviewed and verified R9's care plan/Kardex conflicted with the assessment dated [DATE]. DON confirmed R9 had been measured and assessed for proper sling size on 2/27/26, determined he needed a large sling verses an XL sling. DON was not aware R9's care plan/Kardex had not been updated to reflect the correct sling size of a large sling. During an observation and interview on 3/2/26 at 10:39 a.m., R9 was seated in wheelchair on top of mechanical lift sling that was in color with green trim. Trained medication aide (TMA)-C entered R9's room and stated that she was unable to verify what size R9's sling by the tag, due to the sizing being washed off.ˆ TMA-C stated a tan sling with green trim would be anˆXLˆsling.ˆ TMA-C then walked to a mechanical lift, identified the sling color with the coding sizing chart on the front of the lift that indicated a green trim sling was indeed anˆXLˆsling. TMA-C then verified on R9's Kardex that R9 was supposed to be in a large sling and not an XL sling during transfers using the total mechanical lift.ˆ TMA-C stated, R9 could have fallen out of that sling, and we are lucky he did not. During an interview on 3/2/26 at 11:03 a.m., DON stated NA-D informed her that she had not transferred R9 using the correct sling size, NA-D had only verified the sling size by using the paper nurse aide care guide. DON explained using the sling that was too large could have caused R9 to fall out of the sling during a transfer. DON and TMA-C then removed the incorrect sling out from under R9 and placed the correct size sling in R9's room to be used for the next transfer.ˆ DON stated R9's care plan had been amended to remove any XL sling off his care plan and the paper care sheets removed off the floor to ensure staff were checking the same place to verify correct sling sizes for any residents that need to transferred using any mechanical lift.ˆ The immediate jeopardy that beganˆon 2/25/25 ˆwas removed on 3/2/26 at 2:30 p.m., when it was verified, the facility implemented the following: - The facility has identified all those that use a sit to stand. The facility has assessed each resident and the size of harness needed. The facility educated each member of the nursing staff that will or had potential to use the sit to stand. - R4 and all residents using mechanical lifts were assessed for: Proper transfer method Correct sling/harness size Care plan accuracy. - Sling/harness size was verified for each resident through: Therapy documentation Direct measurement Manufacturer guidelines Care plan accuracy. -Systemic Corrections Policy Review Mechanical lift transfer policy reviewed and updated to: Require sling/harness size documented in care plan and Kardex. Require 2-assist transfers when indicated. Require staff verification of sling size prior to transfer. Require cinching of waist/middle straps before elevation. Documentation Care plans updated to specifically identify: Type of lift Assist level. Sling/harness size. Kardex updated to match care plan. Care sheets updated to match the care plan -Education All licensed nurses and other certified individuals: Manufacturer recommendations Proper sling application Proper strap placement and cinching When sit-to-stand lifts are contraindicated. Always following care plan Education included: In-service training Hands-on demonstration Return competency validation. Competency Quiz ˆ Review of the facility's Mechanical Lift Policy dated 12/25, identified it is the policy to lift and move a resident safely without causing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	serious injury to staff or residents. Procedure as follows: -All mechanical lifts require two staff for operation. -All staff will be trained on proper lift use prior to operating mechanical lifts. -Lifts will be inspected per manufacturer's recommendations. -Lift slings are inspected by nursing prior to use and by laundry when washed. -Inspections will be audited and reviewed and monthly safety meetings. ˆ R3ˆ R3's face sheet dated 2/27/26, identified diagnoses of malignant neoplasm of the brain, heart failure, and osteoporosis.ˆ R3's significant change MDS dated [DATE], identified moderate cognitive impairment, no behaviors, no rejection of care, used a walker and wheelchair, needed partial/moderate assistance for transfers, had one fall with no injury and one fall with injury since admission.ˆˆ R3's fall focus care plan initiated on 1/9/26, identified R3 was at risk for falls related to limited mobility, communication issues, and weakness.ˆ ˆˆGoal to be free from falls. Interventions as follow: -Follow facility fall protocol. -Routine safety checks. Start date 1/9/26. -Anticipate and meet the resident's needs. Start date 1/9/26. -PT evaluate and treat as ordered. Start date 1/9/26. -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes. Start date 1/9/26. -Be sure the residents' call light is within reach and encourage the residents to use it for assistance as needed. The resident need prompt response to all requests for assistance. ˆ R3's fall incident report dated 2/10/26 at 1:40 p.m., identified R3 had an unwitnessed fall in the bathroom after being assisted by a family member and being alone for a minute. R3 attempted self-transfer and fell on her buttocks.ˆ Family member assisted R3 off the floor and reported the fall to staff.ˆ R3's Incident Root Cause Analysis Worksheet dated 2/10/26, identified problem that R3 was left unattended while in the bathroom.ˆ Root cause of fall was left blank.ˆThere was noˆindicationˆof a comprehensive analysis toˆidentifyˆpotential causal factors. R3's fall focus care plan was revised on 2/11/25 to encourage family members not to transfer resident and to ask for staff for assistance. R3's fall incident report dated 2/18/25 at 1:50 a.m., identified R3 was on the bathroom floor with her walker located outside of the bathroom door. Predisposing physiological factors of weakness, gait imbalance, drowsy. Predisposing situation factors of ambulating without assist devices.ˆR3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls.ˆ R3's Incident Root Cause Analysis Worksheet dated 2/18/26, identified a problem that R3 self-transfers at times without a walker. Root causes of fall identified as brain cancer, weakness, and self-transfers.ˆˆAlthough the analysis idetentified potential causal factors, there was no indication of a comprehensive analysis that determined associated interventions that would decrease the risk or prevented falls based on the causal factors that were identified. R8's care plan ˆrevised on 2/19/26 directed staff to place dycem (anti-slip) mat placed in seat of wheelchair,ˆhowever, it could not be determined the rational for placement of the dycem based on the identified causal factors of the fall that were identified on the causal analysis worksheet. R3's fall incident report dated 2/20/26, identified R3 had an unwitnessed fall in her room at 8:05 a.m. R3 was found on the floor lying next to her bathroom.ˆR3 had independently walked to the bathroom by herself and lost her balance.ˆR3's fall incident report did not identify an immediate intervention to mitigate the risk of further falls.ˆ R3's Incident Root Cause Analysis Worksheet dated 2/20/26, identified R3 was found outside of her bathroom on the floor, visual checks every 30 minutes cannot be done when nursing assistants in rooms providing care (R3's record did not identify 30-minute checks had ever been initiated).ˆ Had an inquiry about adding an ultra-low bed.ˆIn review of R3's record although a potential cause was identified there was no indication 30-minute checks had ever been initiated. Additionally even though R3's care plan had been revised 2/25/26 (5 days after the fall) directed staff to check and change every two hours and offer bedpan if the R3 chose, there was no corresponding comprehensive assessment that identified how the frequency and type of toileting program was determined. During an interview on 2/27/26 at 1:16p.m., DON stated R3's falls had been discussed during the IDT daily meetings, however, had not had a comprehensive causal analysis done for each fall to ensure that person-centered interventions (continued on next page)

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	245369	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were put in place for each fall.ˆ DON indicated toileting was the root cause of her falls and should have been addressed before 2/25/26 Review of the facility's Falls-Clinical Protocol dated 2/26, identified the following: Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify potential causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. 2. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors.ˆAfter a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling.ˆMany categories of medications, and especially combinations of medications in several of those categories, increase the risk of falling. 3. The staff and physicians will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. ˆ

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facilityˆfailed toˆensure that 1 of 1 resident (R1) was free of a significant medication error by notˆobservingˆthe rights of medication administration. This caused actual harm for R1 when she was administered another resident'sˆmedicationsˆbecameˆunresponsive andˆhad to be hospitalized for hypotension and acute kidney injury.ˆˆIn addition, based on observation and interview the facility failed to ensure appropriate correction measures after R1's medication errors to decrease the risk or reduce the risk of significant medication errors and could have prevented or reduced the risk additional medication errors that were not significant for 2 of 2 residents (R12, R5) observed during medication pass. Findings include:ˆ R1's face sheet dated 2/27/26,ˆidentifiedˆdiagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners).ˆ R1's admission Minimum Data Set (MDS) dated [DATE],ˆidentifiedˆR1 had moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant.ˆ R1's physician ordersˆidentifiedˆthe following:ˆ -Midodrine (a drug used to treat orthostatic hypotensionˆand increase blood pressure) 5 mg three times per day related to orthostatic hypotension. Do not take if systolic blood pressure (top blood pressure) if greater than 150.ˆ -Vitamin D (supplement) tabletˆ50ˆmicrograms (mcg) one time per day.ˆ -Pantoprazole (drug to reduce stomach acid)ˆ40ˆmilligram (mg) one time per day.ˆ -Apixaban (blood thinner) 5 mg by mouth one time per day.ˆ -Rosuvastatin (drug to treat high cholesterol) 20 mg one time per day.ˆ -Calcium carbonate (supplement) 1500 mg 2 tablets two times per day.ˆ R1's Medication Error incident report dated 2/13/26,ˆidentifiedˆR1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for evaluation.ˆThe investigation notes identified the medications that R1 received included: Atorvastatin 40 mg (milligrams-lipid/cholesterol management), Clopidogrel 75 mg, (antiplatelet-increases risk for bleeding) Duloxetine 30mg, (antidepressant) Empagliflozin 10 mg (diabetic management), Famotidine, (reduces stomach acid) Lamotrigine 100mg (anticonvulsant/mood stabilizer), Losartan 25 mg (treats hypertension) Metoprolol 25 mg (treats hypertension/heart rate control) Potassium 20 mEq,(treats low potassium) and Torsemide 20 mgˆ(diuretic and hypertension) R1's progress note dated 2/13/26 atˆ7:35 a.m.,ˆidentifiedˆnurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident'sˆmedicationˆby mistake. Nurse called the on-call physician and informed the medicationsˆR1 received and was instructed toˆmonitorˆresident for any adverse reactions to any of the medications.ˆ R1's progress note dated 2/13/26 at 9:20 a.m.,ˆidentifiedˆnurse was called into R1's room by nursing assistant because R1 became unresponsive.ˆ R1 was lying with eyes closed, did not respond to verbal commands. Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace. Blood pressure 137/82 (normal blood pressure is under 120/80) and heart rate 92 (normal heart rate is 60-100), respirations 18 (normal respirations 12-18), oxygen saturations 97% (normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED).ˆˆ R1's emergency department (ED) note dated 2/13/26,ˆidentifiedˆR1 was seen in the ED after becoming unresponsive after receiving another resident's medications at 7:35 a.m. A list of medications that was administered was as follows: Atorvastatin 40 mg, Clopidogrel, 75 mg, Duloxetine 30mg, Empagliflozin 10 mg, Famotidine, Lamotrigine 100mg, Losartan 25 mg, Metoprolol 25 mg, Potassium 20 milliequivalent (mEq), and Torsemide 20 mg.ˆˆ R1 had become somnolent (sleepy) and not acting herself at the nursing home so was sent to ED for evaluation.ˆBlood pressure on admission to the ED was 133/59. Blood urea nitrogen (lab value to evaluate kidney function) slightly up trending.ˆR1's blood pressure at 10:58 a.m., decreased to 97/48 millimeters of mercury (mm/Hg) and one liter of fluid bolusˆinitiated. R1 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	was admitted ^for^monitoring^for hypotension and resolution of a mild acute kidney injury.^^ R1's hospital progress note dated 2/14/26,^identified^diagnoses of accidental drug ingestion, hypotension secondary to accidental drug ingestion, blurry vision secondary to accidental drug ingestion, and orthostatic hypotension.^ On 2/14/26^she endorsed blurry vision which the note^identified^this could be a side effect of the medication of the low blood pressures.^ R1's hospital Discharge summary dated [DATE], identified R1 had been hospitalized ^2/13/26 through 2/17/26 after being inadvertently administered another patient's medications at a skilled nursing facility.^ On presentation R1 was somnolent (sleepy and or drowsy) and did not follow commands, had a single episode of hypotension that responded to intravenous (IV) fluids. Laboratory evaluation revealed an acute kidney injury with a creatinine elevated to 1.36 milligram/deciliter (mg/dl).^ The medication error of receiving medications not prescribed to R1 and was admitted for close monitoring of hemodynamics and renal (kidney) function. R1 experienced symptomatic orthostatic hypotension with dizziness and blurry vision on standing,^required^ongoing conservative management including compression wraps, abdominal binder, hydration, and gradual titration of midodrine to 10 mg three times per day. R1's acute kidney injury resolved with IV fluids and avoidance of nephrotoxic agents (medication that cause kidney damage). R1 was discharged on 2/17/26 to another skilled nursing facility.^^ During an interview on 2/24/26 at 4:06 p.m., trained medication aide (TMA)-A^stated^she was agency staff and had worked a handful of times at the facility.^ She had not worked with R1 before and had not seen R1 before. During the day shift on 2/13/26, TMA-A prepared R2's medications, verified R2's picture in the electronic health record (EHR),^identified^R2's room number, however, TMA-A entered R1's room instead. TMA-A did not verify the room number prior to entering R1's and^then entered R1's room to administer the medications.^ TMA-A then^proceeded^to administer R2's medications to R1.^When TMA-A^attempted^to give R1 an inhaler R1 stated, I don't take an inhaler., TMA-A realized her error.^TMA-A left R1's room and^verified on the EHR that she had mistakenly given R2's medications^to R1. ^TMA-A immediately^called the nurse to inform them of error and took R1's vital signs.^ TMA-A^stated^she did not follow the rights of medication administration to ensure the correct resident received the correct^medications.^^TMA-A further^stated^she had not had^orientation^on medication pass or any^previous^education on rights of medication administration^at this facility.^^ During an interview on 2/24/26 at 1:44 p.m., licensed^practical nurse (LPN)-B^stated^she had been notified by TMA-A on 2/13/26 around 7:30 a.m., that R1 received R2's medications.^^LPN-B^stated^she^immediately^came to the unit to check on R1. R1's vitals were^stable; however, she was concerned about getting the wrong^medications.^^LPN-B^stated, I don't even know how TMA-A made that kind of error and told her she should have verified she was giving the medications to the right resident.^^LPN-B further^stated^if TMA-A had performed her rights of medication administration she would have not made the mistake.^^ During an interview on 2/25/26 at 1:04 p.m., medical director (MD)^stated^she considered R1's medication error that occurred on 2/13/26 to be considered a significant error. MD further stated R1 becoming hypotensive and developing an acute kidney injury was^likely caused^by getting medication that were not prescribed to her.^ Staff should have followed the rights of medication administration^for all residents^to^ensure safe medication administration^utilized.^^ During an interview on 2/20/26 at 4:04 p.m., director of nursing (DON)^stated^she had been informed 2/13/26 at 8:00 a.m., that R1had inadvertently received R2's medications at 7:30^a.m.^^DON^stated^she instructed the nurse to^monitor^and ensure the physician had been informed of R1's medication error. The nurse had informed DON that R1 was doing fine and she was being^monitored. DON then^arrived^at the facility around 8:45 a.m.^to^9:00 a.m. Shortly after the DON arrival she^was^notified^that R1 had become unresponsive.^ DON then^immediately^went to R1's room where R1 was found lying in bed and not responding^to verbal commands.^ R1's vitals^had been^taken and were stable, but continued to not respond, so^DON^sent^R1 to the ED for evaluation.^ DON stated R1's medication error occurred because the rights of medication (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	administration had not been followedˆby TMA-A and the wrong medication was given to the wrong resident. R1 was admitted ˆfor observation, but did not return to the facility, so she did not know the outcome.ˆTMA-A had told DON that asˆshe prepared R2's medications, believed she hadˆentered R2's room, however after administering R1 all of R2's pills, she had tried toˆoffer R1 anˆinhaler,ˆwhen R1 statedˆthatˆwas not her medication.ˆˆTMA-Aˆthenˆtoldˆherˆshe realized she had given medicationsˆto the incorrect resident and notified the nurse immediately.ˆˆDON then sent TMA-A home andˆstatedˆshe had providedˆverbal education to the staff that wasˆworking onˆthe rights of medication administration, however, did not have any documentation of her education provided.ˆˆDONˆstatedˆthe facility then began competency testing of the staff that administered medication to ensure that the rights of medicationˆwereˆbeing followed.ˆˆˆ During an interview on 2/24/26 at 12:56 p.m., TMA-Dˆstatedˆheˆhadˆrecently had education and competency testing provided by one of the LPNs to ensure he know how to pass medications correctly.ˆˆHe did not recall exactly what kind of educationˆhe had received. TMA-D was able to name five of the seven rights ofˆmedicationˆadministration, however,ˆwasˆnotˆaware of right rationale or rightˆdocumentationˆbeingˆpart of the rights of medication administration.ˆ During an interview on 2/24/26 at 2:11 p.m., TMA-Bˆstatedˆshˆeˆhadˆrecently received education on the rights ofˆmedicationˆadministration and had competencyˆdone by the administrator.ˆTMA-Bˆstatedˆshˆeˆdid not recall exactly what the education wasˆabout,ˆbutˆbelieved it wasˆjust about howˆthe process ofˆdoing the medication pass correctly and making sure we are doingˆall ofˆthe steps correctly.ˆˆ During an interview on 2/24/26 at 4:52 p.m., administratorˆstatedˆshe was not a licensed nurse, however, hadˆcompleted some of theˆstaff medication administration competenciesˆand education even thought she had not hadˆany formalˆtrainingˆon medication administration or the rights of medication administrationˆtoˆbe able toˆdetermineˆif staffˆ were deemedˆcompetentˆdoing a medication pass. During an interview on 2/24/26 at 4:52 p.m.,ˆDONˆstatedˆshe had not performed any ofˆtheˆmedication administrationˆtraining orˆcompetenciesˆdone with staff. She hadˆa fewˆstaffˆdeemedˆcompetent by a registered nurse, butˆmost ofˆthe staffˆhad been completed by the administratorˆ(who was not a licensed nurseˆnor hadˆanyˆeducation on medication administration)ˆor byˆaˆlicensed practical nurse.ˆˆDONˆstatedˆthe competencies/education that had been completed byˆadministrator,ˆor theˆLPNsˆwould not be considered valid,ˆdue to those staff not having the capability toˆdetermineˆcompetency of the staff or provide education. DONˆstatedˆtheˆstaff thatˆwereˆresponsible for medicationˆadministrationˆshould have had theirˆcompetenciesˆand/or educationˆdoneˆby a registered nurseˆonly. R12's face sheet dated 2/27/26,ˆidentifiedˆdiagnoses of heart failure andˆgastroesophageal reflux disease.ˆDuring an observationˆand interviewˆon 2/25/26 at 7:52 a.m., registered nurse (RN)-B prepared medications for R12 by verbalizing and comparing the order to the medication package label. ˆ RN-B walked to R12 and verified R12's identity with name and date of birth and compared image of R12 in the electronic health record (EHR). RN-B then informed R12 what each medication was and then handed R12 a liquid oral antifungalˆin a small cup, instructed R12 to swish the medication in his mouth then spit the medication out. RN-B then realized the medication was supposed to be a swish and swallow versus a swish and spit.ˆ RN-Bˆstatedˆshˆeˆmustˆhaveˆmisreadˆtheˆorderˆasˆaˆswishˆandˆspitˆversesˆaˆswish and swallow and this would be a medication error.ˆRN-Bˆstatedˆshˆeˆhadˆa kind of audit done recently by theˆadministratorˆwhile she passedˆmedicationˆto ensure she was doing them correctly.ˆˆRN-B did not recall getting any recent education on the rights of medication administration.ˆˆˆ R5's face sheet dated 2/27/26,ˆidentifiedˆdiagnoses of heart failure,ˆParkinson'sˆdisease, and dementia.ˆˆ R5's quarterly MDS dated [DATE],ˆidentifiedˆR5ˆhad intact cognition,ˆno behaviors, took an antianxiety medication, and received hospice services.ˆˆ R5's physician orders dated 1/30/26,ˆidentifiedˆan order for Lorazepam (anti-anxiety) give 1 mg three times per day for anxiety.ˆ R5's Medication Error Incidentˆ Report dated 2/21/26,ˆidentifiedˆR5 received an extra dose of Lorazepam at 4:45 p.m.ˆ During an interview on 2/26/26 at 2:28 p.m., (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	TMA-Cˆstatedˆshe hadˆa recent medication pass audit and competency test given by theˆadministratorˆalong with education on the rights of medication administration. However, despite the education she had made a medication error on 2/21/26 when she gave R5 a extra dose of Lorazepam on 2/21/25.ˆTMA-C explained she had thought R5 had orders for an as needed dose but did not verify R5's physician orders prior to administering the dose of Lorazepam on 2/21/26 at 4:45 p.m.ˆ TMA-Aˆstatedˆshe should have ensured the rights of medication administration were done prior to administering R5's medication, and ifˆsheˆhadˆfollowed the rights of medication administration she would not haveˆmade R5's medicationˆerror. TMA-C recited the rights of medication and identified R5's medication error was the result of not administering the right dose of medication.ˆTMA-Cˆindicated she has continued to pass medications even though she had not received any re-education since the error was made on 2/21/26. TMA-C explained the DON would be providing education on a later date. During an interview on 2/25/26 at 2:59 p.m., DON stated R5's medication error on 2/21/26 was due to TMA-C not performing the rights of medication not being followed and therefore an error happened that had the potential of being a significant error in certain residents.ˆ DONˆstatedˆshe had not given TMA-C formal re-education on the rights of medication administration but was planningˆon doingˆit soon.ˆ Review of the facility's Administering Medications Policy dated 2/26,ˆidentifiedˆthe following:ˆ ˆ-The individual administering medications verifies the resident's identity before giving the residentˆhis/herˆmedications. Methods ofˆidentifyingˆthe residents include:ˆ a. checking identificationˆband;ˆ b. checking photograph attached to medical record; andˆˆ c. if necessary, verifying resident identification with other facility personnel.ˆ The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, rightˆtimeˆand right method (route) of administration before giving the medication.ˆ ˆˆ

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record was maintained for 1 of 1 (R1) resident reviewed for significant medication error. Findings include: R1's face sheet dated 2/27/26, identified diagnoses of heart failure, transient cerebral ischemic attacks (mini strokes), and use of anticoagulants (blood thinners).R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, no behaviors, no rejection of care, diagnosis of renal insufficiency, renal failure, or End Stage Renal Disease, and took an anticoagulant.R1's progress note dated 2/13/26 at 7:35 a.m., identified nurse was called over the walkie talkie by trained medication aide (TMA) to inform this nurse that R1 had been given another resident's medication by mistake. Nurse called the on-call physician to inform of the medications had R1 received and was instructed to monitor residents for any adverse reactions to any of the medications.R1's Medication Error incident report dated 2/13/26, identified R1 had been given R2's medications inadvertently at 7:32 a.m. R1 became unresponsive and had to be sent to the emergency department for evaluation. R1's progress note dated 2/13/26 at 9:20 a.m., identified nurse was called into R1's room by nursing assistant because R1 became unresponsive. R1 was lying with eyes closed, did not respond to verbal commands. Sternal rub (a painful stimulation technique to assess a level of consciousness) done and did get some facial grimace. Blood pressure 137/82 (according to the Mayo Clinic normal blood pressure is under 120/80) and heart rate 92 (according the Mayo Clinic a normal heart rate is 60-100), respirations 18 (according to the Mayo Clinic normal respirations 12-18), oxygen saturations 97% (according to the Mayo Clinic normal oxygen saturations are 95-100%). Ambulance called and R1 sent to emergency department (ED). During an interview on 2/24/26 at 1:44 p.m., licensed practical nurse (LPN)-B stated she had been working on 2/13/26 when R1 received R2's medication. LPN-B stated she had taken R1's vital signs multiple times during her assessments after the medication error, however, did not enter the vital signs in R1's electronic health record (EHR) or any assessments LPN-B had completed on R1. During an interview on 2/24/26 at 4:52 p.m., director of nursing (DON) stated LPN-B should have included each set of vital signs values along with assessments in R1's EHR that she had completed to ensure R1's record was complete and accurate. DON explained that her expectation would be for all licensed staff to ensure the documentation was complete prior to the end of their shift. DON added, If it is not documented, then it was not done. Review of the facility's Charting and Documentation Policy dated 3/26, identified that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.Policy Interpretation and Implementation as follows:The following information is to be documented in the resident medical record:Objective observations.Medications administered.Treatments or services performed.Changes in the residents' condition.Events, incidents, or accidents involving the resident; andProgress toward or changes in the care plan goals and objectives.2. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.3. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the residents' medical chart as permitted by facility policy.4. Documentation of procedures and treatments will include care-specific details, including:the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care.the assessment data and/or any unusual findings obtained during the procedure/treatment.how the resident tolerated the procedure/treatment.whether the resident refused the procedure/treatment.notification of family, physician, or other staff, if indicated; andthe signature and title of the individual documenting

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee identified, investigated, analyzed, and responded high risk issues related to a falls, medication errors, and pressure ulcers by developing and implementing action plans for process improvement. This deficient practice had the potential to affect all 36 residents that resident in the facility. Findings include:SEE F689: Based on observation, interview and document review the facilityˆfailed to ensure safe transfers with a sit-to-stand mechanical lift and/or total body mechanical lift for 2 of 3 residents (R4, R9) reviewed for falls/safety. The facility's failure resulted in immediate jeopardy (IJ) for R4 when staff were observed to use the wrong size harness for sit-to-stand mechanical lift transfer after a previous fall from sit-to-stand lift on 12/21/25 which resulted in minor injuries. In addition, the facility failed toˆcomprehensively investigate/analyze falls for root cause, implementˆappropriate interventionsˆto prevent and/or reduce the risk for future fallsˆfor 1 of 3 residents (R3) reviewed for falls/safety. SEE F760: Based on interviews and document review the facility failed to ensure that 1 of 1 resident (R1) was free of a significant medication error by not observing the rights of medication administration. This caused actual harm for R1 when she was administered another resident's medication became unresponsive and had to be hospitalized for hypotension and developed an acute kidney injury.ˆ SEE 686: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers to prevent deterioration for 3 of 3 residents (R10, R4, R9) reviewed for pressure ulcers.ˆThis resulted in actual harm for R10 who developed a stage 2 pressure ulcer on her sacrum that deteriorated to a stage 3 pressure ulcer.Review of QAPI data from May 2025 through January 2026 identified across all months the facility consistently collected and reported data related to falls, pressure ulcers, and medication errors; however, the documents did not address or include root cause analysis, prioritization of high-risk or recurring issues, development of performance improvement projects, implementation of corrective actions, and monitoring of interventions for effectiveness. Quality documents included the following:May 2025: 5 falls; 3 residents with stage 3 pressure ulcer with no documentation if facility acquired or admitted with; no documentation of medication errors. No documented discussion or action plans.June 2025: No fall data documented; 2 residents with Stage 1 pressure ulcers with no documentation if facility acquired or admitted with; one medication error. No documented discussion or action plans.July 2025: 6 falls with no injury; 2 pressure ulcers (Stage 1 and Stage 2) with no documentation of facilityˆacquired or admitted with; no medication errors. No documented discussion or action plans.August 2025: 8 falls (1 with injury); 1 healed facilityˆacquired pressure ulcer.September 2025: 9 falls with one with injury. Comment added that one fall with major injury/hip fracture; 2 pressure ulcers (Stage 1 and unstageable/DTI), no indication if facilityˆacquired.; one medication error. No documented discussion or action plans.October 2025: 7 falls; no pressure ulcer data; one medication error. No documented discussion or action plans.November 2025: 8 falls (1 with injury); 3 pressure ulcers (Stage 1, Stage 2, unstageable/DTI), no indication if facilityˆacquired; one medication errors No documented discussion or action plans.December 2025: 7 falls (1 with injury); spreadsheet did not identify that the fall with injury involved a mechanical lift; pressure ulcers; no medication errors. No documented discussion or action plans.January 2026: 8 falls (no injury); 3 Stage 2 pressure ulcers and 1 unstageable/DTI; no indication if facilityˆacquired; no medication errors. No documented discussion or action plans.During an interview on 2/26/26 at 4:26 p.m., medical director (MD) stated she was part of the QAPI committee and attends the meetings monthly. MD was unaware of any current action plans that had been put in place by the committee to ensure falls, wounds, or medication errors had been addressed. During an interview on 3/2/26 at 4:39 p.m., administrator stated the facility's QAPI committee meets monthly to bring forward data such as wounds, falls, and (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	03/02/2026

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication errors. The facility had identified a current issue in each of these areas after review of incident reports and wound documentation, however, had not created an action plan to improve quality in any of the areas but only reviewed the data. The administrator stated she was the QAPI committee chairperson who would be responsible for ensuring adverse outcomes are identified, a discussion with the committee, and action plans put in place to attempt/reduce further adverse outcomes. Administrator explained that the QAPI committee had not taken any minutes regarding any discussions during the last four quarters, so therefore had not had any discussion from previous months to review, analyze, and respond to the issues brought forth in the QAPI meetings. The administrator stated, The facility does a great job collecting data, however, does not do a great job with what we do with the data.Review of the Review of the facility's Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Plan dated 11/25/25, identified the following:The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents, caregivers and other partners so that we may realize our mission. To do this, all employees will participate in ongoing QAPI efforts which support our mission. Feedback, Data Systems, and Monitoring: -The facility will put in place systems to monitor care and services, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events every time they occur, and action plans implemented through the plan, do, study, act (PDSA) cycle of improvement to prevent recurrences.Performance Improvement Projects:-The QAPI team at St. Mark's Living will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements. -Based on the result of the review of information, the QAPI team will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI team will determine which problems will become the focus for a performance improvement project (PIP).