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	06/16/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization temperatures for 1 of 1 dishwashers had been appropriately monitored to prevent the risk of foodborne illness. This had the potential to effect all 30 residents residing in the facility. Findings include:During the initial kitchen tour on 6/15/26 at 10:14 a.m., dietary director (DD)-D stated the dishwasher sanitized dishes with heat. Observed a piece of paper on a clipboard in the dishwasher room titled dishwasher with June 2026, written on top. The form had six columns indicating wash and rinse temperatures for each meal service: 6:00 a.m., 12:30 p.m., and 5:30 p.m. All of the wash temperatures indicated 160 degrees Fahrenheit (F). All of the rinse temperatures indicated 150 - 175 degrees F. (Required temperatures for wash are 150-165 degrees F and rinse is 180 degrees F). The rinse temperature was never documented as having reached 180 degrees F. In addition, out of 43 possible entries to document temperatures three times a day, 16 spaces were blank.During an interview and observation on 6/15/26 at 12:55 p.m., observed dietary aide (DA)-A using the dishwasher to clean silverware from the noon meal. DA-A stated wash temperature should be 160 degrees F and rinse 180 degrees F. With dishwasher in operation the wash gauge only reached 132 degrees F and rinse reached 170 degrees F. Despite DA-A having run multiple racks through the dishwasher, neither wash nor rinse temperatures had reached required temperatures. During an interview on 6/15/26 at 1:02 p.m., with DD-D reviewed the June dishwasher temperature log. DD-D acknowledged no rinse temperatures were documented as reaching 180 degrees F. DD-D admitted she didn't monitor the logs and could not say how long the required temperatures had not been reached. DD-D stated dishwasher vendor representative (VR)-E had been there on 6/8/26, and his service visit report indicated required temperatures had been reached.During document review, additional dishwasher logs for March, April and May 2026, were reviewed. Out of three months, only one time was the required rinse temperature of 180 degrees F reached. The logs did not include what the required temperature parameters were and what staff should do if not met.During record review, the vendor report titled Service Visit Report dated 6/8/26, indicated representative VR-E had checked all chemical titrations and temperatures. The report indicated the wash temperature had reached 160 degrees F and the rinse temperature had reached 180 degrees F, yet the dishwasher log for that day did not reflect rinse temperatures of 180 degrees F.During an interview on 6/15/26 at 2:46 p.m., DD-D stated her and maintenance director (MD)-A had been working with the dishwasher, and it had taken running five loads without pausing in between to get the rinse temperature up to 180 degrees F.During an interview on 6/15/26 at 4:29 p.m., DD-D stated the kitchen would switch to paper plates and bowls until the dishwasher temperatures could be corrected and use the 3-compartment sink to wash and sanitize silverware and cups.During an interview on 6/15/26 at 5:45 p.m., VR-E had arrived on-site and had looked at the dishwasher. VR-E stated the dishwasher would hit 180 degrees F, but staff would have to run five loads through to get to that temperature. VR-E stated one of the five heating elements in the booster was out and would have to order a new one which might take three weeks to get. When asked about his service visit on 6/8/26, VR-E stated he had been able to get the required temperatures by running racks through five times. DD-D had not been informed of this, nor did the (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	written Service Visit Report indicate that. Further, VR-E stated he had been aware on 6/8/26, a heating element in the booster was out, but had not ordered a replacement part. During a telephone interview on 6/16/26 at 9:43 a.m., with vendor manager (VM)-F, concerns were expressed about dishwashing rinse temperature, VR-E's service visit on 6/8/26, and the lack of communication with DD-D about findings (having to run the dishwasher five times to reach a rinse temperature of 180 degrees F and being aware the booster needed a new heating element and replacement part not ordered). VM-F stated he had been informed by VR-E and a part had been ordered today. In the meantime, they would find the part within the district and get it replaced today or tomorrow (6/16/26 or 6/17/26).During an interview on 6/16/26 at 9:53 a.m., with DD-D and administrator, both acknowledged the importance of DD-D monitoring dishwasher temperatures, ensuring staff education, and providing staff with written guidance of what temperatures needed to be and what to do if not met. During an interview on 6/16/26 at 10:59 a.m., the director of nursing (DON) and interim DON stated the facility had no incidences of food borne illness.During a telephone interview on 6/16/26 at 3:43 p.m., registered dietician (RD)-G was unaware of dishwasher temperatures not meeting required temperatures. RD-G stated her contract with the facility indicated kitchen audits upon request but had not been asked to do an audit in quite a while. RD-G stated it was necessary for required temperatures to be reached in order to properly sanitize dishes to prevent health risks to residents. Facility Ware Washing policy dated March 2021, indicated all flatware, serving dishes and cookware would be cleaned, rinsed and sanitized after use. The dish machine would be checked routinely to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Run machine until proper temperatures were reached. Record temperatures. Facility Kitchen Food Safety and Sanitation Audit, undated, indicated dishwasher temperatures at 140 degrees F wash and180 degrees F rinse. (It should be noted, 140 degrees F for wash does not meet CMS (Centers for Medicare & Medicaid Services) requirements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure ongoing surveillance for infections, ongoing review of surveillance data, and documentation of follow-up activity and response. This practice had the potential to affect all 30 residents residing in the facility. In addition, based on observation and interview, the facility failed to ensure a glucometer (a small portable device used to measure the amount of glucose in a drop of blood) used on multiple residents, had been disinfected after use on 1 of 1 resident (R17), revewed for infection control practices. Findings include: SURVEILLANCE Review of the facility infection control binder provided 6/15/26, did not include line listing, mapping, or surveillance data for tracking and monitoring infections in the facility. During interview on 6/16/26 at 3:30 p.m., registered nurse (RN)-A stated she was new, had just started yesterday, and was hired to be the infection preventionist. RN-A stated she had searched the prior infection preventionist's office and was unable to locate any infection control tracking, data, surveillance, or mapping documents. During interview on 6/16/26 at 3:32 p.m., interim director of nursing (IDON) stated the prior infection preventionist had left on short notice and they had just replaced her with RN-A. IDON stated she was unable to find any evidence of surveillance or tracking of infections and had not implemented a new method. IDON stated she knew it was a problem and planned to start the program from scratch. IDON had her infection preventionist certificate and planned to have RN-A acquire hers as well. IDON further stated the infection prevention program was not up to her standards and needed to be improved. Facility policy on infection control and prevention was requested but not received. GLUCOMETER CLEANING: R17's face sheet received on 6/17/26, included diagnosis of diabetes. R17's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R17 had diabetes and had received insulin injections in the last 7 days or since admission. R17's physician orders dated 6/3/26, indicated to check blood glucose per device daily at random times, one time a day every 3 day(s). R17's care plan dated 6/12/26, indicated R17 was at risk due to complications of diabetes, and to perform blood sugars per glucose monitor as ordered. During an observation on 6/16/26 at 8:11 a.m., licensed practical nurse (LPN)-C entered R17's room with a small, two-sided plastic tote with handle to obtain a fingerstick glucose. LPN-C removed the glucometer from the tote, obtained the blood sugar, then put the glucometer back into the tote on top of unused needles, without disinfecting it. LPN-C set the tote at the nurses station and sat down to document in the electronic medical record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 6/16/26 at 8:25 a.m., observed LPN-C helping pass breakfast trays, then returned to the nurses station. Glucometer not disinfected. During an interview on 6/16/26 at 10:15 a.m., LPN-D stated LPN-C had left at 10:00 a.m., and LPN-D had not used the glucometer since coming on duty at 10:00 a.m., nor would she need to. During a telephone interview on 6/16/26 at 10:22 a.m., LPN-C admitted she did not disinfect the glucometer after use on R17 – stated she didn't think to and knew she should have disinfected it with a disinfectant wipe to prevent transfer of germs. LPN-C stated the glucometer was used for multiple residents and she had not used it after R17, but acknowledged another nurse could have. During an interview on 6/16/26, at 10:45 a.m., the director of nursing (DON) was informed of findings. The DON expected nursing staff to disinfect glucometers after use to prevent transmission of infection, and called the transitional care unit to ask staff to disinfect the glucometer and the contents of the tote. Facility Glucometer Disinfection policy, undated, indicated the purpose was to prevent cross-contamination and the transmission of infectious diseases during blood glucose monitoring by ensuring proper disinfection. If a glucometer was shared among residents, it must be cleaned and disinfected according to manufacturer recommendations between each use. After testing, disinfect the glucometer before use on another resident using an approved disinfectant wipe. Thoroughly wet all external surfaces of the glucometer and follow the disinfectant manufacturer's required contact time (typically 1–2 minutes or as directed). Allow the glucometer to air dry completely before reuse.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect all 30 residents residing in the facility.Findings include:Review of the facility infection control binder provided on 6/15/26, indicated no antibiotic tracking for correct indications, dosage, duration, resistance, and no 72-hour time-outs (a check that the resident is on the right antibiotic) to review cultures and verify correct antibiotics or resistance to prescribed antibiotics.During interview on 6/16/26 at 3:30 p.m, registered nurse (RN)-A stated she was new to the facility, had been hired to be the infection preventionist, and had not had time to start working on an antibiotic stewardship program. RN-A further stated she was unable to find any documents from the prior infection preventionist to show that antibiotic usage was being tracked and monitored.During interview on 6/16/26 at 3:32 p.m., interim director of nursing (DON) stated the prior employee in charge of antibiotic stewardship had left on short notice. Interim DON was unable to find any evidence of tracking of antibiotic usage for correct dosage, duration, resistance, or that 72-hour time-outs were being completed to ensure proper antibiotic use. Interim DON stated she was aware this was a problem at the facility and would need to get the program restarted. Interim DON stated this was an area that needed improvement and that antibiotic usage should be monitored to ensure residents are getting the correct treatment and prevent worsening of symptoms.Facility policy on antibiotic stewardship was requested but not received.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for residents residing in Golden Oak Hall resulting in numerous large, dark stains throughout the hallway carpeting. This had the potential to affect all 20 residents who resided on the Golden Oak Hall. In addition, the facility failed to repair gaps in an exterior service door allowing the potential for rodents to enter the building. This had the potential to affect all 30 residents who resided in the facility. Finding include: CARPETING On 6/16/26 at 4:00 p.m., observation of the Golden Oak Hall resident hallway revealed multiple dark brown to gray discolorations and stains embedded throughout the carpeted surface. Several stains measured approximately 1 to 3 feet in diameter and were irregularly shaped with darkened edges and concentrated areas of discoloration. The stains were distributed throughout the hallway and were readily visible from a distance due to the contrast between the stained areas and the surrounding carpet. The carpeting appeared worn and soiled, with numerous spots giving the appearance of repeated liquid spills that had penetrated the carpet. Multiple overlapping stains created a large area of visible discoloration extending across a significant portion of the walking path. On 6/16/26 at 4:08 p.m., the interim director of nursing (IDON) observed the hallway carpeting on the Golden Oak Hall and stated the carpet had been shampooed approximately two weeks earlier. The IDON confirmed the carpet was stained and stated, It does not look good, and further stated the carpet needed to be replaced. On 6/16/26 at 4:09 p.m., nursing assistant (NA)-A, NA-B, and NA-C stated the carpet stains throughout Golden Oak Hall were an ongoing concern and not a recent occurrence. NA-A, NA-B, and NA-C stated the carpeting had been shampooed a couple of weeks earlier and confirmed numerous stains remained visible throughout the hallway. NA-A, NA-B, and NA-C stated a beverage cart routinely sits in the hallway and spills occur in the area. NA-B confirmed the condition of the carpeting observed was consistent with its typical appearance and that the staining had been present for an extended period of time. On 6/16/26 at 4:29 p.m., the maintenance director (MD)-A confirmed the carpets in the Golden Oak halls were not clean and acknowledged the appearance and condition of the carpets did not provide a homelike environment. MD-A stated the carpeting was a concern and reported attempts had been made to clean the carpet; however, the staining worsened during humid conditions. On 6/16/26 at 4:49 p.m., the administrator stated the carpeting in the Golden Oak Hall had not been adequately maintained and needed replacement. The administrator stated a professional carpet company evaluated the carpeting the previous fall and indicated replacement was needed. The administrator stated maintenance staff shampooed the carpet approximately three weeks earlier, but the carpeting again appeared heavily stained. The administrator further stated moisture, spills, and coffee spills were contributing factors and acknowledged spills were not always addressed immediately. The administrator stated the carpeting does not look good or homelike, confirmed awareness of the condition, and agreed the carpeting should be replaced. Facility Quality of Life: Home Environment Policy dated 8/25, indicated:The agency/facility will (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure that each patient/resident resides in an environment that is safe, clean, comfortable, and supportive of dignity, independence, and overall quality of life. The home environment shall promote well-being and enable the individual to perform activities of daily living to the highest practicable level. Purpose: To establish guidelines for assessing, maintaining, and improving the patient/resident's home or living environment to promote safety, support independence, maintain comfort, and comply with regulatory standards. Policy Guidelines1. Ensure environmental safety (lighting, temperature, fall prevention). 2. Maintain cleanliness and sanitation. 3. Promote a homelike atmosphere. Assessment Requirements: Environment must be assessed on admission, periodically, and with changes in condition. Intervention and Follow-Up: Address hazards promptly, report unresolved issues, and involve appropriate resources. SERVICE DOOR During the initial kitchen tour on 6/15/26 at 10:14 a.m., with dietary director (DD)-D, observed the double service entrance door that exited the building near the kitchen to the dumpsters outside. The metal door had a gap where the two doors met and was visible by the amount of daylight coming through. DD-D stated the facility had mice in the past and had switched to a different pest control company. DD-D stated she would talk to maintenance director (MD)-A about fixing the door. Resident council meeting minutes dated 3/16/26 and 4/20/26, indicated: Rodents - Pest Control has been called. During an interview on 6/15/26 at 2:45 p.m., family member FM-A stated she had observed mice in R5's room within the last month. FM-A stated the facility had been notified and addressed the issue. During an interview and observation on 6/16/26 at 4:10 p.m., with DD-D and MD-A, observed the gap in the service door. MD-A stated he had been aware of it but didn't know how he could fix it and a new door would be expensive. During an interview on 6/16/26 at 615 p.m., the administrator had been made aware of the gap in the service entrance door and had talked to MD-A about the need to replace it. Facility policy was requested and not received.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 1 of 5 residents (R6), reviewed for unnecessary medications, when the MDS did not reflect opioid (a narcotic pain medication) and diuretic (increases urine production) medications R6 had been receiving. Findings include:R6's face sheet received on 6/17/26, included diagnoses of Parkinson's disease, high blood pressure, congestive heart failure (the heart muscle is too weak to pump blood efficiently), and was receiving hospice care. R6's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderate cognitive impairment, clear speech, could understand and be understood, required substantial assistance or was dependent on staff for activities of daily living. The MDS, section N for medications, did not include the diuretic and opioid medications R6 had been receiving. The section for diuretics and opioids had been signed off as completed by the MDS nurse on 6/10/26. R6's orders indicated the following:--Ordered on 10/10/25, a diuretic: furosemide oral tablet, 30 mg (milligrams) by mouth two times a day for edema (swelling caused by excess fluid trapped in body tissue).--Ordered on 5/11/26, an opioid: fentanyl transdermal patch 72-hour, 12 MCG/HR (micrograms per hour), apply 1 patch transdermal one time a day every 3 days for pain. R6's MAR (medication administration record), indicated R6 received furosemide twice a day in May and June 2026, and fentanyl patch every third day since ordered in May 2026. R6's care plan dated 3/5/26, indicated congestive heart failure and to administer diuretic medication as ordered and to monitor for side effects and effectiveness every shift. Care plan with revised date of 3/2/26, indicated R6 was at the end stage of life and was utilizing hospice services and would be comfortable. During an interview on 6/16/26 at 3:53 p.m., the director of nursing reviewed R6's orders, MAR and MDS and stated diuretic and opioid medication should have been checked-marked on the MDS indicating R6 had been receiving those medications at the time of the quarterly review. The DON indicated they did not have a policy on accuracy of MDS as it was the expectation the RAI (resident assessment instrument) manual directions were followed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to follow physician orders during a dressing change and failed to assess and document the condition of finger wound during weekly skin assessments for a non-pressure skin condition for 1 of 2 residents (R1) reviewed for non-pressure skin In addition, based on interview and document review, the facility failed to ensure physician orders were carried out for 1 of 1 residents (R3) reviewed for unnecessary medications, when a physician was not informed of elevated blood sugar levels.Findings include: DRESSING CHANGE/ WOUND ASSESSMENT R1's significant change in status Minimum Data Set (MDS) assessment dated [DATE], indicated cognitively intact, setup or clean up assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with dressing, personal hygiene and dependent with toileting hygiene and diagnoses included Cerebral Palsy (disease of the developing brain and nervous system that leads to abnormal muscle tone, movement and posture), and rash and other nonspecific skin eruption. R1's care plan dated 4/1/26, indicated R1 was at risk for skin infections due to frequent refusal of showers and interventions included monitor for signs and symptoms of skin infection: redness, warm to touch, drainage, or pain. R1's Wound Care provider note dated 5/19/26, indicated wound Location: right index finger: wash hands, remove old dressings, cleanse wound bases with acetic acid (must be refrigerated after opening, discard remainder after one week), paint wound base with Betadine (if wound starts to feel mushy or has drainage underneath, contact wound clinic for debridement), cover with soft dry gauze, change dressing daily R1's treatment administration record (TAR) dated 6/1/26-6/30/26, indicated: start date 3/23/26 weekly skin assessment-document under assessments every day shift every Wednesday; start date 5/19/26, right index finger: cleanse wound beds with acetic acid. Paint with betadine. (If wound starts to feel mushy or has drainage underneath, contact Wound Clinic for debridement), cover with soft dry gauze, change dressing daily, every evening shift for wound care. R1's skin assessments indicated: 5/18/26, right hand 2nd digit TX (treatment) in place, continues with wound on right hand 2nd digit. Tx orders in place. 5/20/26, continues with wound on right hand 2nd digit. Tx orders in place. 5/21/26, continues with wound on right hand 2nd digit. Tx orders in place. 5/27/26, continues with wound on right hand 2nd digit. Tx orders in place. Nail missing, finger red. 6/2/26, documentation did not include finger assessment 6/3/26, buttocks generalized, moisture associated skin damage (MASD) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/9/26, buttocks generalized, moisture associated skin damage (MASD) On 6/15/26 at 5:16 p.m., R1 was seated in a wheelchair in the dining room and R1's right second finger was observed with a bandage covering the tip of the finger. On 6/15/26 at 5:44 p.m., licensed practical nurse (LPN)-A stated R1 had daily dressing change orders for the finger. LPN-A stated they completed earlier today (6/15/26) and included removal of the bandage and application of acetic acid. LPN-A confirmed Betadine had not been applied because they did not believe it was part of the order. LPN-A then reviewed the physician order in the electronic medical record (EMR) and acknowledged Betadine was included in the order and should have been applied during the dressing change. LPN-A stated she had only viewed part of the order and did not realize Betadine was required. LPN-A further stated Betadine had not been applied during dressing changes the previous week. LPN-A stated R1's finger should have been included in weekly skin assessments and staff would be expected to document the condition of the finger during those assessments. On 6/15/26 at 5:51 p.m., LPN-A was observed to complete dressing change of R1's right index finger and found Betadine in R1's room and applied the Betadine and gauze to R1's. LPN-A stated Betadine should be applied according to the physician's order. On 6/15/26 at 6:29 p.m., interim director of nursing (IDON) and DON stated R1's weekly skin assessments were completed on 5/24/26, 5/27/26, 6/3/26, and 6/9/26. IDON confirmed not all the skin assessments included an evaluation of the R1's finger wound. IDON stated she would expect R1's finger to be assessed and documented during skin checks to determine whether the condition was improving or worsening. IDON further stated she would expect Betadine to be applied during dressing changes because it was included in the physician's order. On 6/16/26 at 3:45 p.m., LPN-B stated weekly skin assessments should include an assessment of R1's finger wound and documentation was expected describing the appearance of the finger to determine whether the condition was improving or worsening over time. Facility Skin Assessment Policy dated 1/25, indicated Policy to conduct comprehensive skin assessments for all residents to prevent, identify, and manage skin integrity issues, including pressure injuries, wounds, infections, and other dermatologic conditions.Purpose: To establish guidelines for assessing, documenting, and managing residents' skin conditions to promote skin health, prevent complications, and ensure timely interventions. Procedure:1. Initial Skin Assessment A comprehensive skin assessment shall be conducted upon admission by a licensednurse. Assessment findings shall be documented in the resident's medical record, noting any existing wounds, pressure injuries, bruises, rashes, or other abnormalities. If skin integrity issues are identified, appropriate interventions shall be implemented immediately, and the physician and interdisciplinary team shall be notified.2. Routine Skin Assessments Daily Observations: CNAs shall observe residents skin during routine care (bathing dressing, repositioning) and report concerns to the charge nurse. Weekly Skin Checks: RNs or LPNs shall perform full-body skin assessments on high-risk residents (e.g., those with limited mobility, incontinence, or a history of pressure injuries). Comprehensive Assessments: Skin integrity shall be reassessed at least quarterly or upon significant change in condition.4. Wound Care Management Any new or worsening wounds shall be assessed 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	06/16/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented, including size, depth, color, drainage, and signs of infection. The wound care team or physician shall be consulted for appropriate treatment plans. Wound care treatments shall be performed as prescribed and documented in the resident's record.5. Documentation and Reporting All skin assessments, findings, and interventions shall be documented in the resident's electronic health record (EHR). Any significant skin changes shall e reported to the physician, family, and interdisciplinary team.6. Staff Training All nursing staff shall receive annual training on skin assessment, wound care, and pressure injury prevention. New employees shall be oriented on this policy and proper skin assessment techniques.Compliance and Quality Assurance: The facility's Quality Assurance Committee shall review skin integrity trends and outcomes to improve resident care. Audits of skin assessments and documentation shall be conducted periodically to ensure compliance with this policy. ELEVATED BLOOD SUGAR LEVELS R3's face sheet received on 6/17/26, included diagnosis of diabetes mellitus (metabolic disease, causing high blood sugar levels). R3's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, speech clear, was understood and able to understand. R3 required substantial staff assist or was dependent on staff for activities of daily living. R3's care plan with revised date of 5/9/23, indicated R3 was at risk for complications related to diabetes mellitus; diabetes medication and/or insulin as ordered and blood sugars per glucose monitor as ordered. R3's physician orders all dated 3/5/26, indicated the following with each order including to notify the provider if blood sugar (BS) over 400 mg/dl (milligram per deciliter): --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 23 unit subcutaneously one time a day. Notify provider if BS (blood sugar) less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 25 unit subcutaneously one time a day. Notify provider if BS less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject 27 unit subcutaneously one time a day. Notify provider if BS less than 100 or over 400. --Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 179 = 0; 180 - 219 = 2 units; 220 259 = 4 units; 260 - 299 = 6 units; 300 - 339 = 8 units; 340 - 379 = 10 units; 380 - 399 = 12 units; 400+ = 15 units, call provider. During record review, R3's blood sugar readings over 400 mg/dl included: 5/25/26 at 12:52 p.m. and 12:58 p.m., 479 mg/dl 5/29/26 at 7:41 p.m., 410 mg/dl (continued on next page)

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	245369	A. Building B. Wing	06/16/2026

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/30/26 at 10:54 a.m. and 11:51 a.m., 424 mg/dl 5/31/26 at 8:12 p.m., 426 mg/dl 6/1/26 at 5:17 p.m., 447 mg/dl 6/1/26 at 9:38 p.m., 427 mg/dl 6/5/26 at 8:32 p.m., 420 mg/dl 6/8/26 at 8:30 p.m., 498 mg/dl 6/10/26 at 11:34 a.m., 416 mg/dl 6/10/26 at 5:01 p.m., 402 mg/dl 6/11/26 at 3:35 p.m., 437 mg/dl 6/11/26 at 5:19 p.m., 473 mg/dl 6/11/26 at 8:00 p.m., 4:39 mg/dl 6/13/26 at 8:07 p.m., 430 mg/dl 6/16/26 at 8:21 p.m., 448 mg/dl During an interview on 6/16/26 at 8:48 a.m., license practical nurse (LPN)-C stated nurses would know when a provider wanted to be notified of a low or high blood sugar if it was included in an order. In addition, LPN-C stated a nurse could also [NAME] over an electronic order in the MAR (medication administration record). LPN-C hovered over R3's insulin order in the MAR and it indicated a sliding scale, and if blood sugar was 400+, give 15 units and notify provider. LPN-C looked in progress notes and of the blood sugars greater than 400 ml/dl, a provider was notified of the BSs over 400 mg/ml on 6/1/26, and 6/11/26, but not the other 10 dates. During an interview on 6/16/26 at 3:36 p.m., with the director of nursing (DON) and interim DON (IDON), informed of findings of blood sugars over 400 mg/dl and provider not informed. IDON stated this had been a problem; they had done some nurse education in spring 2026, on notifying providers on changes in condition, and when orders indicated they wanted to be notified. After reviewing the electronic medication record, neither the DON nor the IDON could verify with certainty the providers were informed of the blood sugars over 400 mg/dl (other than 6/1/26 and 6/11/26). Facility Compliance with Physician orders policy dated 8/2025, indicated the purpose was to ensure all physician (or authorized provider) orders were accurately received, documented, communicated, and implemented in a timely and safe manner to promote optimal resident care and compliance with regulatory standards. All nursing staff must follow physician orders precisely as prescribed. Orders must be verified, documented, and executed promptly unless contraindicated or unclear, in which case clarification must be obtained before implementation.