DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1XUJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00393

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245447**

2.STATE VENDOR OR MEDICAID NO.
(L2) **935742400**

3. NAME AND ADDRESS OF FACILITY
(L3) **SACRED HEART CARE CENTER**
(L4) **1200 12TH STREET SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **59** (L18)

13.Total Certified Beds **59** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	59			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/13/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/15/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245447 October 13, 2017

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

Dear Ms. Mathews Halverson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective September 18, 2017 the above facility is certified for or recommended for:

59 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 59 skilled nursing facility beds located in rooms .

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 13, 2017

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: Project Number S5447027

Dear Ms. Mathews Halverson:

On August 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 9, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 18, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2017, effective September 18, 2017 and therefore remedies outlined in our letter to you dated August 16, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1XUJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00393

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245447**
2.STATE VENDOR OR MEDICAID NO.
(L2) **935742400**

3. NAME AND ADDRESS OF FACILITY
(L3) **SACRED HEART CARE CENTER**
(L4) **1200 12TH STREET SOUTHWEST**
(L5) **AUSTIN, MN** (L6) **55912**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/09/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **59** (L18)
13.Total Certified Beds **59** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	59			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, FHE-NE II 08/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/15/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/15/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 16, 2017

Ms. Rebecca Mathews Halverson, Administrator
Sacred Heart Care Center
1200 12th Street Southwest
Austin, MN 55912

RE: Project Number S5447027

Dear Ms. Mathews Halverson:

On August 9, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 18, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 18, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 7, 8, and 9, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		9/18/17

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

Electronically Signed | 08/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was accurately coded for 2 of 2 residents (R10, R33) reviewed for dental services. Findings include: R10's annual MDS (an assessment) dated 12/28/16, had identified for oral/dental status no oral concerns were present. R10's teeth were observed on 8/7/17, at 3:28 p.m. and surveyor noted missing lower teeth. R10's oral/dental assessment dated 12/27/16 indicated R13 had no oral concerns and was coded, as none of the above were present.	F 278	Employees of Sacred Heart Care Center, who are responsible for the completion of assessments including the MDS, strive to provide accurate coding and information at all times. RN-C recognized and admitted the coding error that had occurred in Section L of the MDS for these two residents. As stated in CMS's RAI Version 3.0 Manual, the rationale for Section L is to identify conditions that might affect the quality of life; overall health; and/or nutritional status so that any problems in this area can be appropriately care-planned. As recognized by the surveyors in the Statement of Deficiencies, reference to the missing or broken teeth was already included in the Care Plans of R10 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING _____ B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 R10's care plan with a last reviewed date of 6/28/17 included, "Self-care deficit: ADL's [activities of daily living] r/t [related to] incomplete performance, sequencing problems, weakness, poor coordination and sitting balance d/t [due to] dx [diagnosis] dementia. 11/11 lower partials missing-won't be replaced per family. Has upper denture and 2 natural lower teeth that are broken off and irregular." R10's progress note dated 8/8/17 included, "Has upper denture that fit fine and 2 natural lower teeth that are broken off and irregular. Does OK with pureed meat texture and rest of food regular texture. Declines dentist." During an interview on 8/9/17, at 10:51 a.m. registered nurse (RN)-C stated R10's care plan was correct. RN-C stated she assessed R10's mouth last night and there was a progress note in the medical record. RN-C stated the annual MDS had been inaccurately coded and stated the MDS should have been coded to reflect R10 had broken natural teeth. R33's admission MDS (an assessment) dated 10/17/16, had identified for oral/dental status no oral concerns were present. R33 was observed on 8/7/17 at 2:50 p.m. and surveyor noted R33 had no teeth and was not wearing dentures. R33's oral/dental assessments dated 10/17/16 and 7/18/17 indicated R33 had no oral concerns and was coded, as none of the above were present.	F 278	R33 so the miscoding of MDS Section L basically had no impact - health-related, financial, or otherwise. RN-C corrected Section L on the MDS by doing modifications for both residents on 8/23/2017. All Clinical Managers were educated on the proper coding of Section L of the MDS and will check the last comprehensive assessment for each of the residents for whom they are responsible to ensure Section L coding is correct. Modifications of the MDS will be completed as necessary. The Clinical Managers will audit Section L of all comprehensive MDS's completed before 12/31/17 and report findings to the QAPI Committee. A determination will be made at the January QAPI meeting as to the need for continued audits.	

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	245447	A. BUILDING _____ B. WING _____	08/09/2017

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SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

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F 278	Continued From page 3 R33's Care Plan with a last reviewed date of 7/26/17 included, "Self care deficit: Dressing, bathing, grooming r/t [related to] incomplete performance, Poor Coordination & balance, sequencing problems, weakness d/t [due to] dx [diagnoses] Alzheimer's dementia, leukemia, anemia, RA [rheumatoid arthritis], and osteoporosis. OT [occupational therapy] done 4/17. Often declines to use her dentures. During an interview on 8/8/17, at 2:45 p.m. registered nurse (RN)-C stated when R33 was admitted she had full and upper dentures and no natural teeth. RN-C stated she coded the MDS as none of the above as R33 was able to eat regular texture food with her dentures. RN-C stated she probably coded that one wrong [referring to the MDS assessment] and confirmed R33 was edentulous and often refused to wear her dentures.	F 278		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		9/18/17

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F 329	Continued From page 4 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to attempt a antidepressant taper after being on the medication for over one year and lacked documentation why it was contraindicated for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R31's significant change Minimum Data Set (MDS) dated 6/14/17, indicated R31 was feeling tired or having little energy. Current diagnosis included depression.	F 329	It is Sacred Heart Care Center□s policy to attempt gradual dose reductions (GDR) for residents who use psychotropic drugs unless a GDR is clinically contraindicated. The Physician□s Progress Note for R31, dated 6/16/17, includes reference to an earlier failed GDR when complete withdrawal of the drug was not well tolerated. RN-A also provided documentation to the surveyor about the behavioral changes that had occurred in August 2015, when a complete withdrawal had been attempted. This also documented that the son had noted at	

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F 329	Continued From page 5 On 8/7/17, at 2:56 p.m., R31 observed seated in a geri chair at end of the hall facing an outside window with her eyes closed. On 8/8/17, at 10:31 a.m., R31 observed seated in a geri chair in the hall sleeping. On 8/8/17, at 11:21 a.m., R31 observed seated in a geri chair at a table in the dining room being assisted by staff with her meal. R31's current care plan, indicated potential for altered mood related to depression and consistently denies feeling sad/depressed when asked other than during times of illness. Psychotropic medication monitoring per nursing home policy, and assess, monitor or intervene as appropriate/necessary. R31's current physician ordered medications included an order for Effexor ER (antidepressant) 37.5 milligrams (mg) in the morning related to depressive disorder. Start date 8/2/2015. Physician notes dated 6/16/17 identified under assessment; chronic depression-in remission on low dose venlafaxine-sequential dose reduction to lowest dose was well tolerated, but complete withdrawal of the drug was not. Identified under psychiatric; affect is stuporous to obtunded. No evidence of medication related toxicity. She appears to be oriented to self, but other orientation is not testable and likely not reliable. Insight and memory are similarly not testable. No evidence of decompensated thought or mood disorder. However, the physician progress notes lacked	F 329	that time that the previous attempt at complete withdrawal of the drug had also failed. The Physician Note of 6/16/17 included a statement that there was no evidence of medication-related toxicity. Because of this deficiency, R31□s physician entered a progress note on 8/23/17 that more clearly restated the above and noted that any additional attempts to withdraw this drug would likely increase suffering due to her terminal state. Physician was informed of the need to repeatedly provide documentation that includes justification as to why any attempted dose reduction would be likely to impair the resident□s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The Director of Nursing will continue to review documentation related to Gradual Dose Reductions and will ensure that there is adequate justification if it is determined that an attempted dose reduction would be likely to impair the resident□s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. If there is any question about the thoroughness of the documentation, the DON will discuss her opinion with the Pharmacy Consultant and the physician, who may be asked to make a more thorough or more timely note. Any concerns about GDR□s will be discussed at the October and January QAPI Committee meeting.	

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F 329	Continued From page 6 documentation of physician justification at a minimum to include information as to why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Behavior Summary Reports dated from 3/15/17 to 8/9/17, with monitoring documented each shift, identified R31 had no episodes of moods or behaviors. On 8/9/17, at 8:03 a.m., nursing assistant (NA)-A and NA-B, both stated R31 displayed no moods or behaviors. On 8/9/17, at 8:08 a.m., licensed practical nurse (LPN)-A stated R31 displayed no moods or behaviors. On 8/9/17, at 12:58 p.m., the director of nursing (DON) stated that registered nurse (RN)-A would have the information related to the clinical justification for the continued use of the antidepressant as RN-A had worked with R31 for years. On 8/9/17, at 1:42 p.m., RN-A confirmed there had not been a dose reduction since 8/2/15. RN-A provided nurse to physician communication documentation dated 8/2/15 and 8/9/15, identifying statements by nursing staff regarding R31 crying and stated this is all that I have. A gradual dose reduction and physician justification of psychotropic medications policy was requested but not received.	F 329		
F 428	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW,	F 428		9/18/17

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F 428 SS=D	Continued From page 7 REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 428		

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F 428	Continued From page 8 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified lack of documentation of physician justification for the continued use of an antidepressant medication for 1 of 5 residents (R31) without an attempt to titrate the medication for the past year or have a clinical justification as to whey the medication should not be titrated. Findings include: R31's significant change Minimum Data Set (MDS) dated 6/14/17, indicated R31 was feeling tired or having little energy. Current diagnosis included depression. R31's current physician ordered medications included an order for Effexor ER (antidepressant) 37.5 milligrams (mg) in the morning related to depressive disorder. Start date 8/2/2015. Physician notes 6/16/17, identified under assessment; chronic depression-in remission on low dose venlafaxine-sequential dose reduction to lowest dose was well tolerated, but complete	F 428	It is the practice of the Consulting Pharmacist (CP) to review each resident□s drug regimen at least monthly, note any irregularities, and provide information about any irregularity in writing to the Director of Nursing, the Medical Director, and the resident□s physician. Based on this deficiency, the term irregularities evidently includes the failure to provide adequate documentation related to a GDR not attempted due to clinical contraindication. In this instance the CP obviously did not find the documentation to be inadequate and based her opinion on notes she made in the resident□s record. The surveyor was referred to those notes. The CP also made a documented return call to the surveyor at 3:15 p.m. on 8/9/17. By definition, a consultant is a person who gives professional or expert advice. Based on our experience, we have never had reason to question her expertise on pharmacy matters. In this particular circumstance, we also shared her opinion.	

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F 428	Continued From page 9 withdrawal of the drug was not. Identified under psychiatric; affect is stuporous to obtunded. No evidence of medication related toxicity. She appears to be oriented to self, but other orientation is not testable and likely not reliable. Insight and memory are similarly not testable. No evidence of decompensated thought or mood disorder. However, the physician progress notes lacked documentation of physician justification at a minimum to include information as to why a attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Behavior Summary Reports dated from 3/15/17 to 8/9/17, with monitoring documented each shift, identified R31 had no episodes of moods or behaviors. R31's consultant pharmacist (CP) recommendation notes dated 7/26/16, identified the following: -7/26/16 No irregularities noted. On 5/17/16, R31's physician reviewed Effexor and documented: chronic depression - in remission on low dose venlafaxine - sequential dose reduction to lowest dose was well-tolerated, but complete withdrawal of the drug was not and "trials of reduction or withdrawal of psychotropic medications currently contraindicated without clear evidence of toxicity. -11/10/16 No irregularities noted. On 9/19/16, resident's physician reviewed venlafaxine and documented: chronic depression - in remission on low dose venlafaxine - sequential dose	F 428	However, the Director of Nursing will continue to review documentation related to Gradual Dose Reductions and will ensure that there is adequate justification if it is determined that an attempted dose reduction would be likely to impair the resident□s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. If there is any question about the thoroughness of the documentation, the DON will discuss her opinion with the Pharmacy Consultant and the physician, who may be asked to make a more thorough note. Any concerns about GDR□s will be discussed at the October and January QAPI Committee meeting.	

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F 428	Continued From page 10 reduction to lowest dose was well-tolerated, but complete withdrawal of the drug was not and trials of reduction or withdrawal of psychotropic medications currently contraindicated without clear evidence of toxicity. Resident on minimum effective dose of this medication. On 8/9/17, at 12:58 p.m., the director of nursing (DON) stated that registered nurse (RN)-A would have the information related to the clinical justification for the continued use of the antidepressant as RN-A had worked with R31 for years. On 8/9/17, at 1:42 p.m., RN-A confirmed there had not been a dose reduction since 8/2/15. RN-A provided nurse to physician communication documentation dated 8/2/15 and 8/9/15, identifying statements by nursing staff regarding R31 crying and stated this is all that I have. On 8/9/17, at 1:44 p.m., CP-A via phone referred to late entry note on 11/10/16 related to the 9/9/16 physician review of the Effexor XR. When asked for clinical justification for the continued use, CP-A stated she wanted to go back in her records to see if she could find a better justification. No return call or message was received. A consultant pharmacist responsibility policy was requested but not received.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 441		9/18/17

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F 441	Continued From page 11 a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 441		

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F 441	Continued From page 12 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to implement a program to prevent Legionella in the facility water systems to prevent cases and outbreak of Legionnaires' Disease. This had the potential to effect all 59 residents residing in the facility, visitors, and staff. Findings include: During an interview on 8/9/17, at 9:42 a.m. with the environmental services director (ESD). The ESD was asked if the facility had developed policies and procedures to reduce the risk of growth and spread of Legionella (Legionella bacteria are microscopic organisms that live in soil and water and are the most common cause of Legionnaires' disease) and other opportunistic	F 441	In addition to stating "no" when asked if the facility had developed written policies related to Legionella or if the facility had documented a facility risk assessment, the ESD informed the surveyor that there had been recent discussions about Legionnaires' disease, the areas of the water supply in our building that could contribute to it, and how we could reduce any associated risk. These discussions were held with the Administrator and at the last QAPI Committee meeting. Staff also verified that issues related to Legionnaires ' disease had been discussed during the previous month's Annual Education.	

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F 441	Continued From page 13 pathogens in building water systems. The ESD answered, "No." The ESD confirmed the facility had not conducted/documented a facility risk assessment to identify where waterborne pathogens could grow and spread in the water system. The ESD confirmed the facility had not implemented a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. The ESD confirmed the facility had not specified testing protocols and acceptable ranges for control measures, and documented the results of testing and corrective actions taken when control limits were not maintained.	F 441	The facility is in the process of completing a written water management plan that will include a written risk assessment; policies to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems; control measures; and testing protocols.	

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	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Sacred Heart Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SACRED HEART CARE CENTER	**1200 12TH STREET SOUTHWEST** **AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sacred Heart Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1997, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 2007, an addition was constructed that was determined to be of Type II (111) construction. Because the original building and the (2) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric	K 511		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 2 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Findings Include: On facility tour between 09:30 AM and 01:30 PM on 8/10/2017, based on observation and interview revealed that the following include: An extension cord in the report room off the main dining area was used for permanent power. This deficient practice could affect the safety of all the 59 residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	A new outlet was installed in the report room, eliminating the need for an extension cord.	