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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 38Y4

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 **10/26/2015** (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 :
Michele McFarland, HFE NE II 11/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245447

November 4, 2015

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.

Effective October 1, 2015 the above facility is certified for:

59 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 4, 2015

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

RE: Project Number S5447025

Dear Ms. Mathews Halverson:

On September 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 10, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 7, 2015 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 September 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 10, 2015, effective October 1, 2015 and therefore remedies outlined in our letter to you dated September 22, 2015, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245447	A. Building B. Wing	10/26/2015

Name of Facility	Street Address, City, State, Zip Code
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **10/01/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/01/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/30/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/30/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/30/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/30/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/30/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/01/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	11/04/2015	10160	10/26/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/10/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245447	A. Building B. Wing **01 - MAIN BUILDING 01**	10/7/2015

Name of Facility	Street Address, City, State, Zip Code
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0050	Correction Completed **10/01/2015**	ID Prefix Reg. # **NFPA 101** LSC K0154	Correction Completed **10/01/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	Correction Completed **10/01/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** TL/kfd	**Date:** 11/04/2015	**Signature of Surveyor:** 35482	**Date:** 10/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/15/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245447	02 - 2007 ADDITION	10/7/2015

Name of Facility	Street Address, City, State, Zip Code
SACRED HEART CARE CENTER	1200 12TH STREET SOUTHWEST AUSTIN, MN 55912

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**10/01/2015**	ID Prefix Reg. # **NFPA 101** LSC K0154	**10/01/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	**10/01/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** TL/kfd	**Date:** 11/04/2015	**Signature of Surveyor:** 35482	**Date:** 10/07/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/15/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 38Y4

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 **09/10/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Michele McFarland, HFE NE II 10/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/20/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 22, 2015

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

RE: Project Number S5447025

Dear Ms. Mathews Halverson:

On September 10, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

<u>Remedies</u> - 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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (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 October 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 December 10, 2015 (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 March 10, 2016 (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 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. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
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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 _____	09/10/2015

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 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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide choices regarding bathing frequency for 1 of 3 residents (R35) reviewed for choices. Findings include: R35's significant change Minimum Data Set (MDS) dated 7/2/15, indicated R35 had moderate cognitive impairment and required total staff	F 242	It is the practice of Sacred Heart Care Center (SHCC) to give its residents the right to make choices about aspects of life in the facility, including bathing, which may be significant to the resident. As stated, residents are asked at the time of admission if they have any preferences about bathing, such as shower or bath, time of day, or frequency. Based on those responses, the resident is placed on the	10/1/15

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

Electronically Signed | 10/01/2015

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F 242	Continued From page 1 assist with bathing. R35's care plan dated 10/15/15, indicated R35 had received a weekly shower or whirlpool with the assist of 1 staff. During interview on 9/8/15, at 6:31 p.m. R35 stated she had bathed every day previously to admission to the home and would like to receive more than 1 shower per week. Wing 1 shower list (undated), indicated R35 was to receive a bath/shower on Saturday day shift. On 9/10/15, at 10:04 a.m. nursing assistant (NA)-C stated R35 required assist for bathing and was scheduled for bathing on Saturday morning according to Wing 1 bath schedule. During review of R35's medical record bathing preferences had not been identified. On 9/10/15, at 1:28 p.m. the director of nursing (DON) confirmed R35 had been showered one time per week, and bathing preferences had not been identified. DON stated "We ask on admission but it's not documented." DON stated preferences should have been documented and choices offered. Request for policy regarding resident preferences however not provided.	F 242	wing¿s shower/bath list. These schedules are updated as needed to best accommodate all residents on the wing and as any new preferences are made known. SHCC will continue with these practices but will provide more thorough documentation of preferences, reasons for changes, or refusals. R35 was interviewed on 9/15/15 regarding bathing preferences. She stated she would like to take a bath but was concerned about the effect bathing would have on her venous ulcers. Her podiatrist was contacted and approval was given for bathing. When asked on 9/26/15 about frequency of bathing, R35 stated that two baths per week would be good. Clinical Managers have reviewed bathing preferences with all residents, made changes as needed, and documented preferences in the medical record. Using this information, each Clinical Manager developed a bathing schedule for her wing and placed them at the nurses¿ stations. NAs will follow the schedule and inform their wing nurse whether or not bathing was completed as scheduled; if not completed, why not; and any other relevant details. The nurse will sign the bath schedule for each resident assigned during that shift, noting any pertinent details and providing documentation in the medical record as needed. The wing nurse will inform their Clinical Manager if any problems/issues arise or if they become aware of a resident¿s change in bathing preferences. These procedures	

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F 242	Continued From page 2	F 242	were reviewed with all nurses at meetings held on 9/30/15 and nursing assistants at meetings on 9/30/15 and 10/1/15. All employees are educated during orientation and at least annually thereafter about the residents¿ right to make choices and are encouraged to offer choices whenever possible. Clinical Managers will review completed bathing schedules at least weekly for four weeks, addressing any issues that may arise. The Clinical Managers will report on their observations and any problems that occurred during the four weeks at the Quality Assurance Committee meeting to be held in early November. A determination will be made at that time if there is a need for further action or a continuation of structured monitoring.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to provide the necessary care and services to maintain skin integrity for 1 of 3	F 309	Sacred Heart Care Center strives to provide all necessary care and services to maintain skin integrity. This includes	10/1/15

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F 309	Continued From page 3 residents (R16) reviewed for non pressure related skin conditions. Findings include: R16's annual Minimum data Set (MDS) dated 5/13/15, indicated the resident had severe cognitive impairment, required extensive assist of two staff for bed mobility, transfer and toileting, required assist of one staff for dressing, personal hygiene, locomotion and used a wheelchair. The MDS indicated R16 had been at risk for pressure ulcer,and used pressure relieving devices. Review of R16's progress notes dated 6/12/15 to 8/25/15, identified diagnosis to include Alzheimer's, heart failure, diabetes, and peripheral vascular disease. Skin/wound progress note dated 6/12/15, noted a blood blister on R16's right great toe which had been identified by a licensed nurse during a diabetic foot inspection. R16's BODY EXAM FLOW SHEET had three entries on the following dates: On 6/12/15 and 7/21/15, the site, type, color and size of the blood blister and had been noted. There had been no change noted in the blood blister from 6/12/15 to 7/21/15, there was no indication if interventions had been reviewed for effectiveness. On 8/25/15, an entry had been made that the site had been clear. During interview with registered nurse (RN)-A on 9/10/15, at 9:06 a.m., RN-A stated she had been aware R16 had a blood blister on her right great toe but was unsure of the cause. Due to the staff not completing a root cause analysis to determine cause of blood blister to develop interventions to prevent more form developing. RN-A verified the	F 309	completing Incident Reports as needed to ensure that documentation is provided showing the incident/injury was investigated; that a root cause analysis was done; and that appropriate interventions were put in place. As stated, the 1 cm x .8 cm blood blister was noted by the nurse in the progress notes but she did not complete an Incident Report. An Incident Report would have triggered a review by the Risk Management Committee, which would have included further analysis of the cause of the injury. That nurse is no longer employed by SHCC. Events/injuries that require an Incident Report were reviewed with all nurses at meetings on 9/30/15. Procedures for skin assessments were updated to include a review of the previous skin assessment to determine if any injury was noted at that time and if so, to determine if an Incident Report had been completed. If not done, the nurse completing the skin assessment will also complete an Incident Report, including a root cause analysis and interventions. The Incident Report would then go to the next Risk Management meeting for further analysis. Wing nurses should report any ¿missed¿ Incident Reports to the DON. The DON will follow-up to identify reasons for any missed reports and will correct individuals or systems as needed to ensure that root cause analysis is performed on a timely basis. DON will report any identified issues, as well as any corrective actions, at the November QA Committee meeting.	

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F 309	Continued From page 4 record lacked documentation to identify the cause, and stated "usually we would do an incident report but there wasn't one." On 9/10/15, at 1:31 p.m., during interview with the director of nursing (DON) it was verified R16's record lacked documentation related to the cause of the blood blister. DON stated it had been her expectation that staff would have filled out an incident report to include causative factors to prevent further blood blisters. Request for policy regarding non-pressure related skin conditions however one was not provided.	F 309	Skin assessments and incident reports will continue to be monitored on an ongoing basis.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess for the safe use of side rails which did not meet the Federal Drug Administration (FDA) guidelines to prevent entrapment for 3 of 30 residents (R9, R68, R14) reviewed for accidents and hazards related to a large gap in the center of the side rail. The facility also failed to ensure implementations of interventions for prevention of accidents for 1 of 2 residents (R65) reviewed for falls.	F 323	The three non-compliant assist bars were removed from beds on 9/8/15 and 9/9/15 and will no longer be used. The policy on Physical Devices was updated to include FDA hospital bed systems guidelines including the acceptable dimensions for assist bars/siderails. Prior to the purchase of any new assist bars, Environmental Services Supervisor will verify that bars meet FDA guidelines.	9/30/15

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F 323	Continued From page 5 Findings include: LACK OF SAFE SIDE RAIL USE ACCORDING TO THE GUIDANCE FOR INDUSTRY AND FDA STAFF HOSPITAL BED SYSTEM DIMENSIONAL AND ASSESSMENT GUIDANCE TO REDUCE ENTRAPMENT DATED MARCH 10, 2016: R9's Admission Record indicted diagnosis including but not limited to a history of falls, anxiety disorder, depressive disorder, and hypertension. During an observation on 9/8/15, at 6:32 p.m. R9's bed had bilateral quarter side rails, with the center opening measuring 5 1/8 x 7 1/4 inches which was larger than the Key Body Part Dimensions pg. 12 of FDA guidance. The quarterly Minimum Data Set (MDS) dated 7/1/15, indicated R9 to be cognitively intact. It also noted R9 required extensive assist of two staff for bed mobility, and limited assist of one staff for transfers. The facility assessment titled Evaluation for use of Assist Bars, dated 7/1/15, identified R9 to have weakness, and the bars would aid R9 in turning side to side and holding self to one side. In regards to transfers, the bars would aid in supporting self, exiting bed more safely, entering bed more safely, and transferring more safely. Recommendations were for two assist bars. R9's care plan dated 4/15/15, identified impaired mobility related to poor coordination, balance, weakness, history of falls, osteoarthritis, deconditioning, and urine incontinence, with a	F 323	R65's falls had been reviewed at Risk Management on 9/8/15 (prior to the surveyor discussing them with any facility staff) and it was noted that there might be some confusion on the part of nursing staff in regard to using the Broda chair intervention for R65. After initially trying a Broda and finding it more difficult to wheel, R65 had consistently refused to use it. For that reason, it was possible that staff quit offering it, not knowing the original Broda had been replaced with one that was easier to move. The Clinical Manager developed a form describing the Broda chair intervention that wing staff were required to read and sign to acknowledge understanding. The intervention has been used successfully since 9/9/15. Although the deficiency states that progress notes for 9/5/15 indicated two falls for that date and that corresponding incident reports had not been completed, this was in fact not true. The referenced progress notes were written shortly after midnight and were actually written about falls that had occurred prior to midnight on 9/4/15 and for which Incident Reports had been completed. To improve documentation and communication about interventions recommended by therapy on a trial basis, the trial interventions will now be written as nursing orders that require monitoring and documentation for the length of the trial. At the end of the trial, a summary	

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F 323	Continued From page 6 goal to be free of falls and injuries. An intervention was listed with the use of two assist bars to help with turning and repositioning. It also noted devices are reviewed at risk management meeting. R68's Admission Record indicated diagnosis including but not limited to history of fall, anemia, major depressive disorder, and anxiety. During an observation on 9/9/15, at 8:22 a.m. R68's bed had bilateral quarter side rails, with the center opening measuring 5 1/8 x 7 1/4 inches again this is larger than the recommended opening for Key Body Part Dimensions pg 12 of the FDA bed rail guide. The significant change MDS dated 7/22/15, indicated R68 as cognitively intact. It also noted R68 required extensive assist of two staff for bed mobility and transfers. The facility assessment titled Evaluation for use of Assist Bars, dated 7/21/15, identified R68 required the use of assist bars due to weakness. It also identified the bars would aid in turning side to side, moving up and down in bed, holding self to one side, and pulling self from lying to sitting position. The bars would also aid in supporting self, exiting the bed more safely, entering the bed more safely, and transferring more safely. It was recommended that two assist bars were needed. R68's care plan dated 4/24/15, indicated impaired mobility, with one staff assist to turn and reposition in bed, and two assist bars to help with turning and repositioning. It also noted a potential for altered mood related to diagnosis of	F 323	progress note will be written with documented notification to therapy of the results. This was communicated to all nurses at meetings held on 9/30/15. Each Clinical Manager will monitor compliance with interventions and stated corrections until the November QA meeting, where they will report findings and observations. Although routine monitoring will continue, a determination will be made at that meeting in regard to need for further reporting. The Risk Management Committee will continue to review all incident reports on at least a weekly basis with an improved awareness of follow-through on recommended interventions.	

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F 323	Continued From page 7 depression and anxiety. R14's Admission Record indicated diagnosis including but not limited to generalized anxiety disorder, anemia, hypertension, and atrial fibrillation. During an observation on 9/8/15 at 5:01 p.m. R14's bed had bilateral quarter side rails, with the center opening measuring 5 1/8 x 7 1/4 inches. The quarterly MDS dated 6/26/15, indicated R14 was cognitively intact. It also noted R14 required extensive assist of two staff for bed mobility, and limited assist of one staff for transfers. The facility assessment titled Evaluation for use of Assist Bars, dated 6/26/15, identified R14 required the use of assist bars due to pain and weakness. It also noted the bars would aid in turning side to side, holding self to one side, and supporting self during transfers. It recommended the use of two assist bars. R14's care plan dated 6/19/15, noted impaired mobility and noted devices are reviewed at the resident's risk management meeting. It also noted a potential for altered mood. On 9/9/15, at 8:26 a.m. DON verified all beds in question were removed, and taken out of circulation. When interviewed on 9/10/15, at 10:50 a.m. DON and environmental services supervisor (ESS) stated maintenance do a monthly check on all rooms, and look for loose side rails, but this is not documented (regarding the rails). ESS verified maintenance does not do any measuring of the	F 323		

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F 323	Continued From page 8 rails for compliance with the FDA recommendations. DON verified she would not expect nursing staff to do any measuring during the assessment. When interviewed on 9/10/15, at 12:33 p.m. registered nurse (RN)-D stated an evaluation is done for each assist bar, but no measuring is completed. The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches, representing head breadth. Facility policy titled Devices and Restraints used at Sacred Heart Care Center, was revised on 9/10/15, and did not contain information regarding FDA hospital bed system demensions and assessment guidance. LACK OF RECOMMENDED DEVICE (BRODA CHAIR) AS AN INTERVENTION TO PREVENT FURTHER FALLS: R65's quarterly Minimum Data Set (MDS) dated 6/3/15, identified R65 was cognitively intact, used a wheelchair for mobility and had sustained two falls since admission to the facility, none of which resulted in injury. A Fall Risk Assessment, dated 3/6/15 identified that R65 had a fall risk score of 16 which indicated that R65 was at a high risk for falls; a	F 323		

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fall risk assessment, dated 6/3/15, indicated that R65 had a risk score of 19 which stated R65 was at a high risk for falls; a fall risk assessment, dated 8/26/15, indicated that R65 had a score of 21 which identified R65 at being a high risk for falls. Based upon R65's scores, the risk had been increasing with each fall risk assessment.

R65's care plan dated 12/10/14, identified R65 had a risk of falls. It was updated on 12/17/14 which recommended to staff that R65 be up in her wheelchair or Broda chair (a specialized chair used to help with posture, prevention of falls and also recommended for people with involuntary movements) daily. From 3/17/15 until 9/8/15, it had not been updated with any new intervention in order to reduce the chance for falls.

R65's Medication Review Report, dated 5/26/15, identified that R65 had a personal history of falls as well as dizziness. It stated that a Broda chair had been ordered for R65 on 5/26/15 and had advised that it be offered as needed for positioning related to poor torso control. It identified the potential for rehabilitation was poor.

R65's Transfer Status Evaluations, dated 3/5/15, 6/3/15 and 8/26/15, all identified that R65 had a history of falls and had tremors due to Parkinson's disease.

R65's nursing assistant care plan, dated 9/3/15, did not indicate that R65 was a fall risk. It contained no information for nursing assistants to follow for a fall prevention plan nor did it contain the use of the Broda chair.

A review of R65's incident reports from 6/26/15 through 9/10/15, indicated that R65 had fallen a

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total of eight times.

The incident report dated 6/26/15, at 6:10 p.m., indicated that R65 had fallen and was found sitting on the floor on her buttocks with her legs out in front of her wheelchair. R65 had been sitting in her wheelchair prior to her fall. No injury had been noted. There was no indication the Broda chair had been attempted.

The incident report dated 7/5/15, at 10:54 a.m., indicated that R65 had fallen and was found to be sitting on the carpeted floor on her buttocks in front of her wheelchair. No injuries had been noted. No use of Broda chair had been included in the report.

The incident report dated 7/5/15, at 12:10 p.m., indicated that R65 had fell from her wheelchair and was found on the carpeted floor sitting on her buttocks with her back resting on the side of the bed next to her wheelchair. R65 stated, "Here I am again." R65 was found to have a tender left thumb with no discoloration or swelling. No interventions had been initiated to prevent a recurrent fall nor had the Broda chair been used.

The incident report dated 7/10/15, at 2:00 p.m., indicated that R65 had fallen. She was found to be sitting on her buttocks on the carpeted floor next to her wheelchair. No injuries were noted and no mention of use of Broda chair.

The incident report dated 8/15/15, at 7:10 a.m., indicated that R65 had fallen from her bed to the carpet. She was found on the floor leaning against the bed sitting upright. No injuries were

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noted. No use or evaluation of Broda chair completed to determine if it was an affective fall reducing intervention.

The incident report dated 8/15/15, at 7:45 a.m., indicated that R65 had fallen from her wheelchair. She was found to be sitting on her buttocks with her wheelchair directly behind her. No injuries were noted. No use of Broda chair indicated.

The incident report dated 9/4/15, at 6:45 p.m., indicated that R65 had fallen from her wheelchair. No injuries were noted. The only recommendation at that time had been for staff to monitor the resident. No interventions were initiated to prevent further falls nor if Broda chair had been used and assessed to be affective to reduce falls.

A Post Fall/Incident Investigation Worksheet which was provided by the facility, dated 9/4/15, at 7:55 p.m., was updated and signed on 9/8/15 by RN-D which identified the need for R65 to continue with physical therapy; there was an education form created for staff to sign off regarding the use of the Broda Chair as there was a question as to if the Broda chair was being consistently by all staff.

Review of the Treatment Administration Record (TAR) from 8/19/15 to 9/8/15, identified that if the resident were to fall from her wheelchair or has increased tremors, offer the Broda Chair as needed. After R65 had fallen from her wheelchair as previously described on 9/4/15, at 6:45 p.m., and 7:55 p.m., there was no indication that R65 was offered the Broda Chair.

A document provided by RN-D dated 9/4/15, the

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document discussed R65's fall which occurred that day. It noted that the intervention which had been put in place beginning on 8/19/15 which required staff to offer the Broda chair in case of falls had not been implemented. It did at this time describe the need to reeducate staff that the Broda chair is available for R65 to use. It noted that staff have to sign a form which stated that the Broda Chair was offered to R65. This intervention was changed from an as-needed basis to a scheduled documentation.

Review of the progress notes dated 9/5/15, at 12:10 a.m., indicated that R65 was found by the nursing assistant on the floor in her room. The nurse on duty had been called to R65's room who noted that R65 was sitting on her buttocks with her arms to the side and her legs straight out. R65 denied any pain or discomfort. No injury was noted. No incident report was filed. No post fall/incident investigation report had apparently been completed. No indication if the Broda chair had been utilized before the fall.

Review of the progress notes dated 9/5/15, at 12:36 a.m., indicated that R65 was found by the nursing staff on the floor in her room. R65 was observed to be sitting and leaning against the wall with her arms in front of her body and her legs straight out. R65 denied having pain. R65 was assisted to her wheelchair and then transferred to her bed. No incident was apparently filed. No post fall/incident investigation report had been completed nor if the resident was utilizing the Broda chair.

During an observation on 9/8/15, at 7:41 p.m., R65 was observed to be sliding down in her wheelchair. R65 was gyrating in circular motions

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continuously. R65 stated that she fell a lot. R65 was observed to be leaning heavily to one side.

During an observation on 9/9/15, at 9:13 a.m., R65 was observed to be in her recliner tilting to the right side of the recliner with no support.

During an observation on 9/9/15, at 1:48 p.m., R65 was observed to be in room sitting in the Broda chair. R65 stated that the Broda chair was comfortable. R65 was upright in the chair and appeared comfortable.

During an observation on 9/10/15, at 7:27 a.m., R65 was observed to be in her room sitting upright in the Broda chair. Her posture was upright and R65 appeared to be comfortable.

During an observation on 9/10/15, at 11:33 a.m., R65 was observed to be in the dining hall sitting in the Broda chair. R65 was sitting in an upright posture and appeared to be comfortable.

When interviewed on 9/10/15, at 11:51 a.m., nursing assistant (NA)-A stated that R65 usually had episodes of slipping out of her wheelchair at night. She stated that she had not seen R65 in the Broda chair in the past three months. She noted R65 was in the Broda chair today and stated it was the first time she had seen R65 in the Broda chair in the past three months. NA-A noted that R65 had typically fallen by slipping out of her wheelchair.

When interviewed on 9/10/15, at 12:16 p.m., RN-D, noted that R65 recently had two falls. She admitted that R65 had an order for the Broda chair to be on an as-needed basis. She stated that R65 can be in her wheelchair if her tremors

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are not terrible. She stated that the Broda chair had been ordered back in May 2015 but she noted that it had not been offered for R65 to use as an intervention by the staff. RN-D stated, "It wasn't being offered as I would have liked." Referring to the intervention put in place back on 8/19/15, RN-D stated, "The intervention was there but wasn't being utilized as it should." She stated that she reviewed R65's falls and noted that staff were not documenting that the Broda chair had been offered to prevent future falls.

When interviewed on 9/10/15, at 12:40 p.m., nursing assistant (NA)-B stated she had never been aware of R65 ever using a Broda chair. She stated that for a fall prevention strategy for R65, she would stay with the resident and call for help. She would then get her gait belt (used for assisting nursing assistants in repositioning residents) and straighten R65 in her wheelchair. NA-B did not mention she would have used the Broda chair.

During an interview on 9/10/15, at 1:09 p.m., the Director of Nursing (DON), stated that originally after R65 had been falling, R65 had been declining to use the Broda chair. She stated that after reviewing R65's last fall that it should be reiterated to R65 to use the Broda chair. The DON did state that it should have been offered after R65's previous falls.

A review of the facility's Falls and Fall Risk, Managing policy, reviewed on 2/6/14, identified that staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff would identify appropriate interventions to reduce

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F 323	Continued From page 15 the risk of falls. If falling were to recur despite initial interventions, staff would implement additional or different interventions, or they would indicate why the current approach should remain relevant. The staff were to monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		9/30/15

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F 334	Continued From page 16 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure documentation of informed	F 334	The Infection Control Nurse designee contacted all residents or responsible	

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F 334	Continued From page 17 consent to receive annual flu vaccinations occurred at the time of the vaccination for 2 of 5 residents (R12 & R16) who had received the influenza vaccination. Findings included: R12 and R16's records were checked for influenza education prior to the administration of the 2014 influenza vaccine season. However, none was located nor provided when requested from staff. During an interview on 9/10/15 at 11:30 a.m. the acting infection control coordinator licensed practical nurse (LPN)-A stated, somewhere down the line we changed to the one time consents. The one time consent is in reference to giving the resident on admission to facility the education and consent before giving the influenza and this one consent/education is good for as long as the resident stays in the facility even if they stay for two or more years. The influenza education/consent is not given the second year or after to residents. LPN-A was not aware of exactly when this practice changed. During an interview on 9/9/15, at 2:38 p.m. with the director of nursing (DON) pertaining to record review for resident influenza vaccinations, DON stated, "Consent forms for the influenza vaccination are singed on admission and they are good for their entire stay." The DON further explained the education for influenza was presented to residents or medical power of attorneys, however the presentation of education is not documented in the resident's record. Facility policy Influenza Vaccinations-Employees and Residents dated 9/12 did not reflect current standards of documentation for informed consent.	F 334	parties during the month of September to provide information about components of this year's influenza vaccine and to obtain authorization for its administration. Additionally, all were mailed an information sheet describing risks/benefits. Education and consent/declination were documented in the medical record. Residents (or responsible parties) will continue to receive information about the influenza vaccination and be asked to give consent for its administration at the time of admission. Additionally, before shots are administered each fall, residents (or responsible parties) will receive education about risks/benefits and the components of the current year's vaccine. They will be asked to consent to or decline the vaccination. Education and consent/declination will be documented in medical record annually. The Infection Control Nurse, or designee, will use the medical records to compile a checklist of residents noting that education has been given and consent has been obtained prior to the administration of the influenza vaccine. The Infection Control nurse will report information about the number of residents who received a flu shot to the Safety/Infection Control Committee annually. The Influenza Vaccinations Policy for Residents has been updated to reflect current standards of documentation for	

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F 334	Continued From page 18	F 334	informed consent.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R62) observed for administration of inhaled medication were administered according to manufacturer directions. Findings include: The quarterly Minimum Data Set (MDS) dated 6/24/15, indicated R62 to have moderately	F 425	The Oral Inhalers Policy was updated to include instructions that residents using steroid-containing inhalers should rinse mouth and spit out the water after use. Physician¿s orders for steroid-containing inhalers were updated to include instructions for rinsing and spitting. This information was reviewed with all nurses at meetings on 9/30/15.	9/30/15

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F 425	Continued From page 19 impaired cognition. The facility Medication Review Report, indicated R62 had an physician order dated 9/25/14, for Symbicort Aerosol 160-4.5 mcg and was to inhale two puffs orally two times daily for chronic airway obstruction. During an observation on 9/10/15, at 7:50 a.m. registered nurse (RN)-C administered Symbicort two puffs to R62 in her bedroom. R62 then left her room, stating she would return from the dining room when breakfast came, for her insulin injection. When interviewed on 9/10/15, at 8:24 a.m., RN-C stated R62 rinses her mouth independently after administration of the inhaled medication in her bathroom, and this morning reminded R62 when she returned for her insulin. RN-C verified mouth should be rinsed with water and spit out after administration of Simbicort. When interviewed on 9/10/15, at 8:56 a.m. R62 stated she typically does rinse her mouth after use of the inhaled medication, but typically goes to the dining room and gets water from the table, rinses, and then swallows the water. R62 stated staff are aware this is her habit. When interviewed on 9/10/15, at 8:58 a.m. RN-D verified the mouth should be rinsed after administration of Simbicort, and the water should be spit out, not swallowed. Symbicort Inhalation Aerosol Medication Guide indicated users are to rinse the mouth with water and spit the water out after each dose. Do not swallow the water. This will help to lessen the	F 425	The DON will complete at least five spot checks during October to ensure compliance with the policy as written. She will report findings at the November QA Committee. A determination will be made at that time whether there is a need for further action or a continuation of structured monitoring.	

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F 425	Continued From page 20 chance of getting a fungus infection (thrush) in the mouth and throat. Facility policy titled Inhalers - Oral, review date 2/7/14, does not instruct staff or resident to rinse the mouth after use of Symbicort or any inhaled medications.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		9/30/15

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F 431	Continued From page 21 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the facility failed to ensure Fentanyl patches (transdermal narcotic patches used for pain) were appropriately destroyed and disposed of to prevent potential diversion which had the potential to affect 4 of 4 residents (R51, R59, R17, R30) who had received Fentanyl patch which were stored for destruction. The facility also failed to ensure accurate medication labeling for 2 of 7 residents (R74, R10) who had received insulin. Findings include: LACK OF A SECURED SYSTEM TO PREVENT UNAUTHORIZED ACCESS TO FENTANYL PATCH BEFORE BEING DESTROYED WHEN STORED IN CABINET IN DIRECTOR OF NURSING'S (DON'S) OFFICE: When interviewed on 9/10/15, at 1:35 p.m. licensed practical nurse (LPN)-B stated the Wing 1 medication (Med) cart had 26 used Fentanyl Patches placed on a sheet of paper, and the wing currently had 26 used patches, for one resident with current orders, one resident who was deceased, and others that had been discontinued. LPN-B stated when a new patch is applied, the old patch is placed on a piece of paper, labeled with the resident's name, date	F 431	Procedures for destroying Fentanyl patches were changed on 9/14/15 to allow for the destruction of a Fentanyl patch at the time of removal of the patch from the resident. Two nurses are required to document the disposal. Due to safety concerns, the facility will no longer accept unlabeled medications or any insulin brought from home. These changes were reviewed with all nurses at meetings held on 9/30/15. The DON will check Narcotic Book 2x per week for four weeks to determine if new procedure for destruction of Fentanyl patches is being followed. DON will also check insulin weekly for four weeks to ensure that all are labeled with name and the date opened and address any problems with floor staff at that time. She will report findings to QA Committee in November to determine if there is a need for continued monitoring.	

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removed, and signed by the nurse. The paper is then placed in a Ziploc bag and placed in the medication cart. The director of nursing (DON) takes the Ziploc bag from the medication cart.

When interviewed on 9/10/15, at 2:34 p.m. LPN-C stated the Wing 3 did not currently have any Fentanyl patches. LPN-C stated they are on wing 2. When a new patch is placed, the old one is put on a paper, and placed in a plastic bag in the med cart. The old patches are not counted by nursing with the narcotics. LPN-C indicated there are typically quite a few used patches in the baggie until the DON comes to remove them.

When interviewed on 9/10/15, at 2:40 p.m. registered nurse (RN)-C indicated used patches are placed on a half sheet of paper and stored in the medication cart until the DON removes them. They are not counted. RN-C stated, "If it gets full I ask the DON to come get them." RN-C stated there was currently one used patch in the medication cart on Wing 2.

When interviewed on 9/10/15, at 2:51 p.m. DON stated she collects the used patches from the medication carts "pretty frequently", and verified the used patches are not counted by nursing with the other narcotics. DON stated when she brings them from the medication carts, they are entered onto a sheet which lists the resident's name and the date the patch was removed. The list along with the used patches are then stored in the double locked box. This list is reconciled once per month with the consultant pharmacist while in the facility. At this time, the patches are removed from the paper and cut up. During observation of the double locked box no Fentanyl patches were visible. The DON indicated she had the Fentanyl

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patches in her office, and pulled out an unlocked drawer and counted 57 used fentanyl patches. The DON verified the drawer did not lock. The DON stated the used patches were kept in the drawer until she was able to write them on the list and place them in the double locked box. The DON said her office door is unlocked during the day when she is in the facility and locked when not working.

When interviewed on 9/10/15, at 4:18 p.m. consulting pharmacist (CS) stated the facility keeps a record of each Fentanyl patch which is removed, and attached to a sheet. These are then turned in to the DON for destruction after removal. If the patches are not turned in right away, a record should be kept until removed by the DON. CS indicated it would be best practice if given to the DON at least daily, or compiling accounting for the patches until destroyed. CS stated the patches are reconciled and destroyed approximately monthly by herself and the DON. They are reconciled by looking to see that a patch is dated every three days. CS verified it would not be acceptable if the patches are not double locked at all times.

The following residents have a doctors order for fentanyl patches for pain control:

R51's Physician order, discontinued 8/1/15, indicated R51 had received Fentanyl Patch 72 hour 100 microgram per hour (mcg/hr).

R59's Physician order dated 8/2/15, indicated R59 received Fentanyl Patch 72 hour 25 mcg/hr.

R17's Physician order dated 4/26/15, indicated R17 received Fentanyl Patch 72 hour 50 mcg/hr.

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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 431	Continued From page 24 R30's Physician order dated 3/12/14, indicated R30 received Fentanyl Patch 72 hour 50 mcg/hr. Facility policy titled Fentanyl Patch Destruction Policy noted staff were to place Fentanyl Patch Disposal Slip with used patch into a plastic zip lock bag and lock in controlled substance lock box on the medication cart. They were then to notify DON to remove used Fentanyl Patch from medication cart and place into DON double locked box until pharmacist comes to the facility to destroy narcotics. LACK OF INSULIN LABELING FOR PRESCRIPTION MEDICATIONS: During observation on 9/10/15, at 1:17 p.m. of medication storage on the Wing 3 medication cart, Lantus (injectable insulin) flexpen noted without a pharmacy label or resident name on it. LPN-A stated this belonged to R10, and wrote R10's name on the flexpen with a marker. When interviewed at this time, LPN-A stated insulin should be labeled with the resident's name and dated when opened. During observation on 9/10/15, at 1:35 p.m. of medication storage on the Wing 1 medication cart, an open vial of Lantus insulin for R74 was noted with no date opened. When interviewed at this time, LPN-B verified insulin is to be dated when opened.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		9/30/15

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F 441	Continued From page 25 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper	F 441	RN-A immediately recognized her mistake. She is new to long term care	

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F 441	Continued From page 26 disposal of sharps for 1 of 3 observations during blood glucose testing, and failed to ensure proper cleaning of glucometers for 3 of 3 observations after obtaining blood sugar testing. This had the potential to affect 7 of 7 residents receiving blood sugar testing in the unit who used the same glucometer. Further, the facility failed to ensure a sanitary device for 1 of 3 medication crushing machines. The facility also failed to identify causative organisms of urinary tract infections (UTI) prior to the initiation of antibiotic therapy that in turn lead to the inability to track and trend infective organisms. Findings include: LACK OF SAFE DISPOSAL OF BLOOD SOILED LANCET TO PREVENT OTHERS FROM BEING EXPOSED TO POTENTIAL DISEASES WHEN HANDLING BLOOD SOILED LANCET: During an observation on 9/9/15, at 5:05 p.m. on Wing 2, registered nurse (RN)-A obtained a blood glucose reading on R28. After completion, RN-A removed her gloves and disposed of them, along with the blood soiled lancet used to poke R28's finger, directly into the trash in the bathroom. Upon question, RN-A stated the lancet is to be disposed of in the sharps container on the medication cart. RN-B was training RN-A, and stated RN-A needed to remove the lancet from the trash. When questioned upon safe removal, RN-B stated RN-A needed to remove the lancet from the trash. When interviewed on 9/10/15, at 8:58 a.m. RN-D stated it would not be acceptable to remove a lancet from the trash, and verified it should have been placed into the sharps container after pocking the finger.	F 441	and being watched by a surveyor was rather unnerving. The appropriate disposal of lancets was reviewed with all nurses at meetings held on 9/30/15. Alternatives to digging through trash to recover a lancet, should the need ever arise, were also discussed. Also at these meetings, all nurses were re-educated on the appropriate procedures for cleaning glucometers immediately after use and for reporting damaged equipment to the DON or maintenance. On 9/28/15, the Medical Director, who is also the primary physician for most residents, was informed of MDH's directive to request culture and sensitivity for all UA's related to UTI¿s so that the most effective antibiotic could be ordered. In addition, facility nurses will include the request for culture and sensitivity when obtaining a physician¿s order for a UA related to possible UTI. This information was also reviewed at the meetings on 9/30/15. The DON will observe glucose testing, lancet disposal, and the cleaning of the glucometer at least two times per week both the day and evening shifts. No glucose testing is done on the night shift. Observations will occur over the next four-week period. Findings will be reported to the QA Committee in November. After these initial observations, the Infection Control nurse will observe a glucose testing, lancet disposal, and glucometer cleaning at least once per month from November 2015 through	

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F 441	Continued From page 27 When interviewed on 9/10/15, at 10:00 a.m. director of nursing (DON) stated a lancet should not be dug out of a trash container, and is to be placed into a sharps container. DON stated it would be best practice to remove the trash bag and place all of it into a large sharps container. Facility policy titled Sharps Disposal review date 9/10/15, noted all sharps are dropped unsheathed and unbroken directly through the opening in top of the receptacle (reference to a sharps container). LACK OF RECOMMENDED DISINFECTING FOLLOWING USE OF MULTI-RESIDENT USE GLUCOMETER: RN-A was then observed to place the glucometer (machine used to test blood glucose) in a black case and placed it in the top right drawer of the medication cart. When interviewed on 9/9/15, at 5:15 p.m. RN-A and RN-B both stated they were trained to clean the outside of the glucometer with an alcohol wipe, and stated the night nurse would clean it good. During an observation on 9/10/15, at 7:40 a.m. on Wing 3, licensed practical nurse (LPN)-A obtained a blood glucose reading on R10. LPN-A returned to the medication cart, and cleaned the outside of the glucometer with a Super Sani-Cloth (germicidal disposable wipe), and immediately placed it in the top right drawer of the medication cart. When interviewed at this time, LPN-A stated she was trained to clean the glucometer with the	F 441	March 2016. The need for continued observations will be discussed at the April 2016 QA Committee meeting.	

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F 441	Continued From page 28	F 441		

Super Sani-Cloth after every use by just wiping it down and letting it air dry. LPN-A denied knowledge of any time frame the glucometer should remain wet. When observed within one minute, the glucometer was completely dry.

During an observation on 9/10/15, at 7:50 a.m. on Wing 1, RN-C performed a glucose reading on R62. RN-C then brought the glucometer back to the medication cart, and cleaned the outside with a Super Sani-Cloth, and placed the glucometer on top of the medication cart.

When interviewed at this time, RN-C stated she was trained to use the Super Sani-Cloth after each use, and the glucometer dried immediately. Further, RN-C stated she was trained only to wipe it off, and was not informed of any amount of time the glucometer was to remain wet. The glucometer appeared dry immediately when set on top of the medication cart.

When interviewed on 9/10/15, at 8:58 a.m. RN-D stated the glucometers are to be cleaned with the Super Sani-Cloth by wiping it off, and then it is to be wrapped in a wet Super Sani-Cloth for two minutes.

Facility policy titled Blood Glucose Meter Cleaning review date 2/6/14, noted to disinfect the meter, wipe it down with a Super Sani-Cloth and thoroughly wet the surface of the meter. The treated surface must remain visibly wet for two minutes, then let it air dry.

LACK OF MAINTAINING MEDICATION DEVICE USED TO CRUSH MEDICATION FOR RESIDENTS WAS KEPT IN A SANITARY CONDITION:

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F 441	Continued From page 29 During an observation on 9/9/15, at 5:05 p.m. on Wing 2, a Silent Knight (pill crusher) on top of the medication cart was noted with yellow tape around the handle, and appeared to have dirt in the crevices. When interviewed at this time, both RN-A or RN-B stated it had always been this way, and neither knew why the tape was on the handle. When interviewed on 9/10/15, at 10:00 a.m. DON stated it would not be acceptable to have tape covering the handle of the pill crusher. Upon observation of the crusher, DON stated the handle was loose, and was taken for repair. A facility policy for maintaining medication devices in a sanitary condition was requested and none provided. LACK OF DETERMINING IF ANTIBIOTIC MEDICATION WAS AFFECTIVE TO DESTROY URINARY TRACT INFECTION ORGANISM (UTI): Monthly infection control logs were reviewed from March of 2015 through August 2015. March 2015 log revealed one occurrence of a urinary tract infection (UTI) that was treated with an antibiotic. A urine culture and sensitivity test to determine pathogen that would indicate the most affective antibiotic was not evident in the medical record prior to the initiation of antibiotic therapy. April's log revealed one of two diagnosed UTIs were treated with an antibiotic without evidence in the medical record of culture and sensitivity test prior to the initiation of antibiotic therapy. May's log revealed two of two diagnosed UTIs were treated with an antibiotic without evidence in the medical record of culture and sensitivity test prior to the initiation of antibiotic therapy.	F 441		

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F 441	Continued From page 30 June's log revealed three of three diagnosed UTIs were treated with an antibiotic without evidence in the medical record of culture and sensitivity test prior to the initiation of antibiotic therapy. July's log revealed one of two diagnosed UTIs were treated with an antibiotic without evidence in the medical record of culture and sensitivity test prior to the initiation of antibiotic therapy. August's log did not reflect any cases of UTIs. During an interview on 9/10/15, at 2:25 p.m. the director of nursing (DON), stated, "We don't get a culture and sensitivity for every urinary tract infection." During the course of the interview the DON indicated a new infection control nurse took over in March 2015 and had not yet had formal infection control training, however planned to do so in the near future. DON indicated the facility did not have an infection control program policy.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document the facility failed to ensure 24 out of 24 dining room chairs were maintained in a clean and sanitary condition for resident use. This had the potential to effect all residents eating in the dining room.	F 465	All dining room chairs have been thoroughly cleaned. The Environmental Services Supervisor moved all seats on the chairs slightly forward, creating a small gap which will lessen the accumulation of crumbs and allow for easier cleaning. The Dietary Department	10/1/15

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F 465	Continued From page 31 Findings included: During a dining observations on 9/8/15, at 6:57 p.m. and on 9/9/15, at 8:15 a.m. 24 dining room chairs were observed to have large amounts of dried food debris along the back edge of the chair cushions. In addition the legs of the chairs had a grayish/blackish film. During an interview on 9/9/15, at 8:30 a.m. the certified dietary manager CDM-C was asked who was responsible for cleaning the dining room chairs. CDM-C stated "housekeeping cleans the chairs." During an interview on 9/9/15, at 8:46 a.m. housekeeper (H)-A stated, "I think the kitchen does that [cleans the chairs], I've never done that", in response to the question "How often do you clean the dining room chairs." During an interview on 9/9/15, at 8:53 a.m. H-B verified the soiled condition of the chairs and indicated the dining room chairs were cleaned once or twice a year and was not sure when the last time the chairs had been cleaned. At 10:55 a.m. H-B was cleaning the chairs and stated according to supervisor the chairs had last been cleaned earlier in the summer. H-B further explained, "housekeeping does not clean the chairs on a daily basis and doesn't think anybody is wiping them down on a daily basis." During an environmental tour on 9/10/15, at 4:39 p.m. with maintenance worker MW-A several dining room chairs continued to be in the same condition as first observed. MW-A verified the soiled condition of the chairs and explained the chairs had not been on routine cleaning schedule. MW-A explained she had been doing them monthly until her position was assigned added job duties that did not allow time to clean the dining room chairs.	F 465	will wipe down chairs as needed when any food or crumbs are observed on the seats and has established a biweekly schedule to thoroughly clean chair seats. Nurses and NAs were told at meetings on 9/30/15 and 10/1/15 to also be more aware of any food or crumbs on the dining room chair seats when they are assisting residents to stand or transfer after meals. Wipes are available on all dining room tables and can be used to quickly clean a chair seat. What was described as a grayish/blackish film on the chair legs was primarily dark scuff marks made by shoes on the beige legs of the chairs. All legs have been cleaned and were put on a schedule for regular quarterly cleaning by housekeeping/maintenance. Individual chair legs will also be cleaned on an as-needed basis. The QA Coordinator will check all dining room chairs for cleanliness two times per week for the next four weeks. She will notify the Certified Dietary Manager or the Environmental Services Supervisor of any observed problems as needed and will document and report these to QA Committee at its meeting in November.	

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F 465	Continued From page 32 During an interview on 9/10/15, at 4:45 p.m. environmental director (ED)-B indicated housekeeping was responsible for the deep cleaning of the chairs but not for routine daily cleaning. ED-B indicated the chairs had been last deep cleaned in June 2015.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/01/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as two separate buildings. Sacred Heart Care Center is a 1-story building with a partial basement. The building was constructed at 2 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. Because the original building and the 1 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 fully sprinklered. 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		

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K 000	Continued From page 2 The facility has a capacity of 59 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2. In a fire emergency, this deficient practice could adversely affect 55 of 55 residents. FINDINGS INCLUDE: On facility tour between 09:00 AM and 12:00 PM on 09/15/2015, while reviewing fire drill reports provided by facility staff, it was confirmed that no fire drills were conducted on the PM-Shift during 2nd Quarter of 2015.	K 050	The QA Coordinator will inform the Administrator of scheduled fire drills at the beginning of each month. The Administrator will place the date on her calendar, which she looks at every day, and will remind the QA Coordinator on the day of the scheduled drill.	10/1/15

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K 050	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (BK) at the time of discovery.	K 050		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:00 PM on 09/15/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (BK) at the time of discovery.	K 154	The existing policy has been updated so there is a separate policy addressing the out of service plan for the fire sprinkler system.	10/1/15

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 _____	**09/15/2015**

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 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 12:00 PM on 09/15/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (BK) at the time of discovery.	K 155	The existing policy has been updated so there is a separate policy addressing the out of service plan for the fire alarm system.	10/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**09/15/2015**

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	INITIAL COMMENTS FIRE SAFETY 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New 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	K 000	EPOC	

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

Electronically Signed | 10/01/2015

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 **02 - 2007 ADDITION** B. WING _____	**09/15/2015**

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as two separate buildings. Sacred Heart Care Center, In 2007, an addition was constructed that was determined to be of Type II (111) construction. The building is fully sprinklered. 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. The facility has a capacity of 59 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		10/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**09/15/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 050 SS=D	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 18, Section 18.7.1.2. In a fire emergency, this deficient practice could adversely affect 55 of 55 residents. FINDINGS INCLUDE: On facility tour between 09:00 AM and 12:00 PM on 09/15/2015, while reviewing fire drill reports provided by facility staff, it was confirmed that no fire drills were conducted on the PM-Shift during 2nd Quarter of 2015. This deficient practice was confirmed by the Facility Maintenance Director (BK) at the time of discovery.	K 050	The QA Coordinator will inform the Administrator of scheduled fire drills at the beginning of each month. The Administrator will place the date on her calendar, which she looks at every day, and will remind the QA Coordinator on the day of the scheduled drill.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour	K 154		10/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. BUILDING **02 - 2007 ADDITION** B. WING _____	**09/15/2015**

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K 154	Continued From page 3 period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:00 PM on 09/15/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (BK) at the time of discovery.	K 154	The existing policy has been updated so there is a separate policy addressing the out of service plan for the fire sprinkler system.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	K 155		10/1/15

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